Patient Information

PATIENT LAST NAME FIRST NAME MI

MAILING ADDRESS CITY STATE ZIP CODE

HOME & CELL NO. RELIGIOUS PREF.

SOCIAL SECURITY NO. DATE OF BIRTH AGE SEX MARITAL STATUS

EMPLOYER OCCUPATION

EMPLOYER ADDRESS EMPLOYER PHONE NO.

SPOUSE OR PARENT NAME DOB EMPLOYER PHONE# S.S.#

DEPENDENT CHILDREN NAMES: DOB

MEDICAL INSURANCE INFORMATION:

INSURANCE COMPANY PRIMARY INSURED NAME

ACKNOWLEDGEMENT AND AUTHORIZATION

I consent to treatment as necessary or desirable for the care of the patient named, including but not restricted to drugs, medication, lab test or other studies which may be used by the physician or his/her qualified designate.

I acknowledge full responsibility for the payment of such services and agree to pay my bill in full at the time of service unless other arrangements are made with the financial department. I understand insurance coverage is an arrangement between the insurance carrier and the patient. Lake Jackson Family Practice will assist in billing my insurance company, but I am ultimately responsible for payment should my insurance fail to pay within a reasonable period of time.

I authorize Lake Jackson Family Practice to release information required to my insurance or third party payor (including employer or my employer's Worker's compensation carrier) for the purpose of determining benefits. I understand that such records may include information regarding HIV/AIDS testing, substance abuse and/ or mental health issues. I also authorize Lake Jackson Family Practice to bill my insurance or third party payor and receive payment directly from them for services rendered.

This authorization shall remain valid for a period of two years (2) years or until such as I revoke it in writing. A photocopy or a faxed copy of this authorization shall be deemed as valid as the original.

SIGNATURE OF PATIENT OR LEGAL GURDIAN DATE