LANE PHYSICIAN GROUP

EMPLOYEE VERIFIED:_____DATE_____

PATIENT INFORMATION SHEET

ALLERGIES_____
LAST NAME_____ BIRTHDAY _____
FIRST NAME_____ HOME PHONE_____
ADDRESS_____ WORK PHONE_____
CITY_____LA_____ZIP_____ CELL PHONE _____
EMPLOYER/SCHOOL(ATTENDING)_____ SOCIAL SEC. # _____
FULL TIME STUDENT? _____YES____ NO DRIVER'S LICENSE#_____
SPOUSE_____SPOUSE DOB_____
PATIENT E-MAIL ADDRESS_____
DOES PATIENT HAVE A LIVING WILL?_____ YES_____NO
RESPONSIBLE PARTY INFORMATION (Parent or Guardian)
LAST NAME_____ DRIVER'S LICENSE#_____
FIRST NAME_____ HOME PHONE_____
ADDRESS_____WORK PHONE_____
CITY_____LA_____ZIP_____BIRTHDAY_____
EMPLOYER/SCHOOL (ATTENDING)_____ SOCIAL SEC. # _____
FULL TIME STUDENT? _____YES____ NO

INSURANCE CARRIER
1). INSURANCE NAME_____ INSURED'S NAME_____
GROUP# _____ POLICY # _____
ADDRESS_____
PHONE#_____
INSURED'S DOB_____ INSURED'S SS#_____
PATIENT RELATIONSHIP TO INSURED_____(Self, Spouse, Child)
IF YOU HAVE MORE THAN ONE INSURANCE, PLEASE ALLOW THE RECEPTIONIST TO COPY ALL OF THE CARDS.
EMERGENCY NOTIFICATION
NAME_____ RELATIONSHIP_____
PHONE_____ CITY_____

PLEASE READ AND SIGN
I understand that all services are charged to the patient, and as the patient, I am responsible for all charges not paid by my insurance. I hereby authorize Lane Physician Group to obtain my medication history by means of electronic access which becomes part of my permanent record. I hereby indemnify the physician office and its agents from any and all responsibility relative to obtaining such information. I acknowledge and give consent for treatment. I authorize Lane Physician Group to release my medical and financial information to my insurance carriers as necessary to receive payment. I authorizes payment to be made to Lane Physician Group. If I have no insurance, full payment is made it time of service. As of Nov. 1, 2017 our office will charge a fee of $35.00 for not showing up for your appointment. When a time slot is left open because a patient does not call and cancel their appointment there is not enough time to notify another patient that is in need of being seen.

Date_____ Signature_____