LAFAYETTE
INTERNAL MEDICINE CLINIC

Last Name: _____ First Name: _____ Middle Initial: _____

Gender : M F **Social Security #: _____** If refused, *please initial* _____

Marital Status: Single Married Divorced Widowed Separated

Date of Birth: _____/_____/_____

Race: White Native American Black Asian American Indian/Alaska Native Other

Ethnic Group: Hispanic Non-Hispanic Unknown **Declined *please initial:*** _____

Primary Language: _____

Primary Provider: □ ACKLEY □ DENNIS □ DOWDEN □ HEBERT

□ MIER □ PETRY □ RIGGS

Street Address/City/State/Zip: _____

Mailing address (if different than above): _____

Telephone: Home #:_____ Cell #:_____ Work #:_____Ext____

E-mail address: _____

Preferred Contact Method: Phone Text Mail Email Secure Email

Preferred Reminder Method: Cell # Home # Work # Mail

Preferred Pharmacy (Include Street/Location): _____

Preferred Mail Order Pharmacy (if applicable):_____

Patient's Employer: _____ **Employer's Phone #:** _____

Employer's Address/City/State/Zip: _____

Occupation: _____ Full-Time Part-Time Self-Employed Retired Student

---

GUARANTOR INFORMATION (Policy Holder's Info)

Guarantor Name: _____ **Guarantor DOB**: _____ **Guarantor Sex: M F**

Guarantor Address/City/State/Zip _____

Relationship to Guarantor: Self Spouse Child Other: _____

INSURANCE INFORMATION

Primary Insurance: _____ **Tertiary Insurance: _____**

Secondary Insurance: _____

******A copy of your insurance card and other ID is required for billing******

EMERGENCY CONTACT

Name: _____ **Relationship to patient:** _____

Mailing Address/City/State/Zip: _____

Home # _____ **Work #** _____ **Cell #** _____

Referring Doctor: _____ **Referring Doctor Phone #**:_____

How did you hear about Lafayette Internal Medicine Clinic: _____

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Lafayette Internal Medicine Clinic or any holder of medical information about me to release to the Health Care Financing Administration and its agents (Medicare) or insurance companies or third parties, any information needed to determination these benefits or the benefits payable for related services.

ASSIGNMENT OF BENEFITS

I request that authorized Medicare or insurance payments of medical benefits be made to Lafayette Internal Medicine Clinic or to any consulting physician or entity used in connection with this service (to be used only if necessary to file claims).

GUARANTOR RESPONSIBILTY

I understand that I am ultimately responsible for payment of any and all charges for medical services rendered by Lafayette Internal Medicine Clinic, and if this assignment is rejected, modified, or not paid within a reasonable time after it has been filed, it will be my responsibility to pay any unpaid charges in full. If it is necessary to collect unpaid fees for services rendered, I agree to pay the charge assessed by the collection service, legal counsel or court. This authorization and assignment may be revoked by me at any time by a written notice. I agree that a photocopy of this form may be used in used in lieu of the original.

Signature of insured/patient _____ Date: _____