Life Center
Family Medicine

Patient Intake Information

First:_____ MI:_____ Last:_____ Sex: M / F Date of Birth: _____

Marital Status: (circle one) Single / Married / Other Social Security# _____ Drivers Licenses # _____

Race: (circle one) Caucasian / African American / American Indian / Asian / Hispanic / Other: _____

Physical Address: _____ Zip Code: _____

Mailing Address: _____ Zip Code: _____

Primary Phone: _____ Secondary Phone: _____

Email Address: _____ (Used for Patient Portal and appointment reminders.)

Employer _____phone # _____

Preferred Pharmacy: _____ Location: _____

Insurance drug plan _____

Financially Responsible Person This is the person that will receive statements for any outstanding balance

Name _____phone # _____

Address_____

Insurance Information

Primary Insurance Plan: _____ Policy #: _____

Policy holder name _____ Date of Birth of Policy Holder: _____

Secondary Insurance Plan: _____ Policy #: _____

Policy holder name _____ Date of Birth of Policy Holder: _____

Referral

How did you hear about our office? Internet Flyer Newpaper Friend Famliy member

Who can we thank for referring you to our office? _____

Notice of Privacy Practices and no show

I, _____ hereby acknowledge that I am aware of, and understand the Life Center Family Medicine Notice of Privacy Practices. I also understand that I may receive a copy of the Notice of Privacy Practices and/or the Missed Appointment Policy upon my request. By signing this form, I am consenting to allow Life Center Family Medicine to use and disclose my personal information and my protected health information to carry out my treatment, payment, and health care. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I don't sign this consent, or later revoke it, Life Center Family Medicine may decline to provide treatment to me. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Life Center Family Medicine or insurance company to release any information required to process my claims. The above information is true to the best of my knowledge.

Initial: _____ If you do not keep your appointment and have not called to cancel or reschedule within the allotted time limits (24 hours before appointment on prior business day), you will be charged a "no-show" fee of $25 for medical appointments or $35 for counseling appointments. Late cancellations are considered a "no-show." (To cancel a Monday appointment, cancellation is expected on the prior business day which is typically Friday.)

_____ _____

Patient/Guardian Signature Date