



DEMOGRAPHICS

			DEMOGRAFIIC	_				
LAST NAME		FIRST NAME		MIDDLE INITIAL				
SOCIAL SECURITY NUMBER			SEX			PREFIX/SUFFIX		
DATE OF BIRTH (mm/dd/yy)			STATUS (please check one) Single Married Divorced Widowed Partner		ced	STUDENT (please check one) □ No □ Full Time □ Part Time		
STREET ADDRESS		CITY/STATE			ZIP CODE			
HOME PHONE (include area code)			WORK PHONE			CELL PHONE		
RACE (please check one)			ETHNICITY (please check on	ne)		PREFERRED LANGUAGE		
☐ White ☐ Black/African American ☐ Asian ☐ Hawaiian/Other Pacific Islander ☐ Other Race American ☐ Indian/Alaska Native			☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown			☐ English ☐ Spanish Or other:		
EMPLOYER	JOB TITLE/STATUS	;	EMPLOYER ADDRESS			EMPLOYER PHONE NUMBER		
PREFERRED PHARMACY	RED PHARMACY PHONE NUMBE		R	EMAIL AI	AIL ADDRESS			
PREFERRED METHOD OF COM		REMINDEI		☐ Cell Pho	une.	☐ Home Phone		
	C	ONTAC	CT/GUARANTOR IN	FORMA	TION			
CONTACT (please check at least	one)	LAST NA	AME		FIRST NA	AME	MIDDLE INITIAL	
☐ Emergency Contact ☐ Insured ☐ Author	☐ Next of Kin prized to Seek Treatment							
SSN (social security number)	DATE OF BIRTH (mm/dd/yy)	RELATIO	ONSHIP TO PATIENT		SEX	MARITAL STATUS	•	
HOME ADDRESS		CITY/ST	ATE		ZIP COD	E HOME PHONE		
EMPLOYER		V	WORK PHONE		JOB	JOB TITLE		
If the Gua	arantor information is	left bla	ank, the patient will be	e assume	d to be t	he responsible/billed pa	nrty.	
			AST NAME FIRST		Г NAME	MIDDLE INITIAL		
	uthorized to Seek Treatment							
SSN (social security number)	DATE OF BIRTH (mm/dd/yy)	REI	LATIONSHIP TO PATIENT	SEX		MARITAL STATUS		
HOME ADDRESS		CIT	CITY/STATE		ODE	HOME PHONE		
EMPLOYER			WORK PHONE		JOB	TITLE		

RANCE POLICY INFORMATION	Over
RANCEPOLICY INFORMATION	

INSU

POLICY NUMBER	GROUP ID		EFFEC	TIVE DATE
TYPE (please check one only) ☐ Health ☐ Auto ☐ Work, Comp.	PRIMARY INSURANCE	P END DATE	COPAY	MENT AMOUNT
	□ Yes □ No		Office	: \$ Specialist: \$
NAME OF INSURANCE COMPANY/PLAN	INSURANCE COMPANY	Y ADDRESS		PHONE NUMBER
INSURED'S NAME	DATE OF BIRTH (mm/dd	//vv)	HOME PHON	JF.
		.557		
INSURED'S MAILING ADDRESS	 	PRIMARY CARE PHYSICIAN	J (ncn) &/or REFER	RING PHYSICIAN
INSCRED SIMILER OF INDUCES		KIMIKT CAKETITISICIA	(pep) caron Ren Enc	Kai (O I II I BICINII (
SECONDARY	INSURANCE INF	ORMATION (if app	olicable)	
POLICY NUMBER	GROUP ID		EFFEC	TIVE DATE
TYPE (please check one only)	PRIMARY INSURANCE	PEND DATE	COPAY	MENT AMOUNT
☐ Health ☐ Auto ☐ Work. Comp.			Office	: \$ Specialist: \$
□ Other	l les l No		Office	. φ Specianst. φ
NAME OF INSURANCE COMPANY/PLAN	INSURANCE COMPANY	ADDRESS		PHONE NUMBER
INSURED'S NAME	DATE OF BIRTH (mm/dd	//yy)	HOME PHON	NE .
I authorize my insurance benefits to be paid di	rectly to the physici	an and I am financia	ılly responsibl	e for all charges. I hereby
I authorize my insurance benefits to be paid directions to the release and re-disclosure of my my account for any amounts due from me or an benefit plan. This consent applies to LMG, PC, LMG, PC or any of its affiliates. I also authorian employee has suffered an exposure incident Administration.	nedical record to en ny third party payo or any of its affiliat ze LMG to test my	able or facilitate the r, health maintenanc tes or agents, lenders blood for hepatitis an	collection, verse organization, or any third and/or the AID	rification or settlement of n, insurer or other health party servicer acting for S virus, if in their opinion;
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Relationship (if signature is not of Patient) **Signature of Person Obtaining Consent**