PATIENT IDENTIFICATION

			Male Female	
Patient Last Name	First	Middle Initial	Sex	Birth Date

Street Address/Apt. No.	City	State	Zip

Patient's Social Security Number	Home Phone	Cell Phone	Work Phone

Patient's Employer	Work Address	Occupation

Emergency Contact (person NOT Living With You)	Relationship to Patient	Contact Phone #

Parent's Name (if a dependent)	Spouse Name (if married)	All other names patient has used, including maiden name

Spouse or Parent's Employer	Work Address	Work Phone

Other Family Members Living With You (Names and Ages)

Church or Religious Affiliation	Pastor/Priest/Rabbi/Other Spiritual Leader	I was referred here by

List medications patient is allergic to: ____

INSURANCE INFORMATION Please present your insurance identification card(s) or letter to the receptionist.

Single Married (Marital Status is required for insurance claims – please check one)

Medicaid. My caseworker's name is: ______________________________

Medicare. Please complete the Medicare Authorization and Medicare Secondary Payer Questionnaire on the other side.

Group or Private Health Insurance. Policyholder ______________________ Policyholder Birth Date ___________

Today's visit is the result of a work injury. Employer authorizing treatment: _________________________________

No insurance. I am personally responsible for payment of my medical bills.

BILLING INFORMATION Payments are due at the time of service. Insurance copayments not paid on the day of service are subject to a billing fee. Notify the receptionist if you have any questions.
Complete the following section if someone other than the patient is responsible for payment. For adults, you or your spouse can be the Responsible Party. For patients under 19, the Responsible Party must be a parent or legal guardian with whom the child lives. No one else can be the Responsible Party unless they give their written consent.

Responsible Party Last Name	First	Middle Initial	Relationship to Patient

Street Address/Apt. No.	City	State	Zip	Home Phone

Responsible Party's Employer	Work Address	Occupation	Work Phone

ACKNOWLEDGEMENT and AUTHORIZATION

I acknowledge that I have received a copy of the Notice of Privacy Practices. I authorize the release of any medical information necessary to process my insurance claims. I authorize payment of benefits to Lincoln Family Medical Group, P.C. if my provider participates in my insurance plan. If my provider does not participate in my insurance plan, I take responsibility for payment of all fees for services received. I understand that payment of the portion of my bill for which I am responsible is due at the time of each visit.

______________________________________ ____________

Signature of patient (parent or legal guardian if patient is a minor) Date