LIGHTHOUSE HEALTHCARE, LLC

Marital Status: PLEASE CIRCLE

PATIENT INFORMATION

____

Single Married Widowed Divorced

PLEASE PRINT

Referred By

LAST NAME FIRST NAME MIDDLE NAME

DATE OF BIRTH SSN

MALE OR FEMALE
(*PLEASE CIRCLE*)

MAILING ADDRESS CITY/ STATE/ZIP

( ) HOME PHONE # ( ) CELL PHONE # ( ) WORK PHONE #

SPOUSE/PARENT/GAURDIAN LATE NAME FIRST NAME MIDDLE INT.

EMERGENCY CONTACT INFORMATION

(MAKE SURE THIS OERSON DOES NOT LIVE IN THE SDAME HOUSE HOLD)

LAST NAME FIRST NAME MIDDLE NAME

RELATIONSHIP

MALE OR FEMALE
(*PLEASE CIRCLE*)

MAILING ADDRESS CITY/ STATE/ZIP

( ) HOME PHONE # ( ) CELL PHONE # ( ) WORK PHONE #

PHARMACY INFORMATION

PHARMACY NAME ( ) PHONE NUMBER

AUTHORIZATION

I hereby authorize payment directly to the physician of the surgical and/or medical benefits. I understand that I am responsible for any portion of my bill not covered by my insurance company. I authorize release of information for insurance claim purposes. I hereby state that all of the above information is correct to the best of my knowledge. My signature indicates that I have read the above statement.

PATIENT SIGNATURE: ______________________________ **DATE:** ________________

GUARDIAN/ LEGAL REPRESENTATIVE: ______________________________ **DATE:** ________________