LIGHTHOUSE HEALTHCARE, LLC

Marital Status: PLEASE CIRCLE

Single Married Widowed Divorced

PATIENT INFORMATION

PLEASE PRINT

Referred By _____

_____

LAST NAME FIRST NAME MIDDLE NAME

_____ MALE OR FEMALE

DATE OF BIRTH SSN (*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 PERSON DOES NOT LIVE IN THE SAME HOUSEHOLD)

_____

LAST NAME FIRST NAME MIDDLE NAME

_____ MALE OR FEMALE

RELATIONSHIP (*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: _____