Lawrenceville Internal Medicine Associates, LLC

Patient Information

Last Name	First Name	Middle	Gender	Marital Status	Birthdate	Age	Social Security #

Preferred Language	Race	Ethnicity

Address	Home: Work:	How did you hear of us?
Address 2	Cell: Email:	

City	State	Zip Code	Employer Name & Address	Occupation

Emergency Contact	Phone	Pharmacy	Pharmacy Phone

Insurance Information

Medical Insurance Name & Address	Policy Holder	Relationship	Policy ID	Group ID
1				
2				

Guarantor (Person to be billed, if different than patient)

Last Name	First Name	Middle	Gender	Marital Status	Birthdate	Social Security #

Address	Home:	Work:	Email:

City	State	Zip Code	Employer Name & Address	Occupation

HIPAA Approved Contacts

Last Name	First Name	Relationship	Home:	Cell:
Last Name	First Name	Relationship	Home:	Cell:

May we leave detailed messages on your home phone? Yes No	May we leave detailed messages on your work phone? Yes No
May we leave detailed messages on your cell phone? Yes No	May we email you detailed messages? Yes No

Patient's or Authorized Person's Signature

I the undersigned give my authorization to treat and assign directly to Lawrenceville Internal Medicine Associates, LLC, all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am ultimately financially responsible for all approved and covered charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions. I understand that payment is expected at the time of service.

Signature	Date