

WELCOME TO LANCASTER MEDICAL, LLC

Please answer all of the questions so that we are better equipped to meet your health care needs

PATIENT INFORMATION

Name: First _____ MI _____ Last _____ Maiden: _____

Street Address _____

City _____ State _____ Zip _____ Birth Date _____

Phone: Home _____ Work _____ Ext. _____ Social Security # _____

Emergency Contact: Name _____ Relationship _____ Phone _____

(Name a person not living with you)

PRIMARY INSURANCE

Insurance Company _____

Policy Holder: Name _____ Phone _____

Address _____

Birth Date _____ Sex: M F Social Security # _____

Plan Name _____ Group # _____ Suffix # _____

ID#/Policy Number _____ Effective Date _____

Co-Pay Amount _____ Primary Physician _____

SECONDARY INSURANCE (If applicable)

Insurance Company _____

Policy Holder: Name _____ Phone _____

Address _____

Birth Date _____ Sex: M F Social Security # _____

Plan Name _____ Group # _____ Suffix # _____

ID#/Policy Number _____ Effective Date _____

Co-Pay Amount _____ Primary Physician _____

PLEASE READ AND SIGN THE FOLLOWING: I directly assign all medical/surgical benefits to Lancaster Medical, LLC and understand that I am financially responsible for all charges that are not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits.

Patient Signature

Date