WELCOME TO LANCASTER MEDICAL, LLC

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

First Name _____MI _____ Last Name _____ Maiden _____

Street Address_____

City _____State _____ Zip Code _____ Birth Date _____ Social Security #_____

Home Phone _____ Cell Phone _____ Circle: Male Female

Emergency Contact: Name _____Relation _____Phone _____

Circle: Employed Full Time Employed Part Time Unemployed Retired

Circle: Student Part Time Student Full Time **Circle:** Married Never Married Divorced Widowed

Circle Ethnicity: Hispanic Non-Hispanic **Circle Primary Language:** English Spanish French Other

Circle Race: White Black Asian Indian/Alaskan Pacific Isle Other

LAST Primary Care Physician: _____

Reason for Changing Primary Physician: _____

PRIMARY INSURANCE

Insurance Company _____

Subscriber Information: Name _____ DOB _____ Social Security #_____

Address _____Phone _____ Sex M F

Insurance ID # _____ Group # _____ Suffix # _____

Plan Name _____ Effective Date _____ Co- Pay Amount _____

SECONDARY INSURANCE (If applicable)

Insurance Company _____

Subscriber Information: Name _____ DOB _____ Social Security #_____

Address _____Phone _____ Sex M F

Insurance ID # _____ Group # _____ Suffix # _____

Plan Name _____ Effective Date _____ Co- Pay Amount _____

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. I have also received and understand Lancaster Medical Notice of Privacy Practices.

Patient Signature **Date**