Lawrence Medical Associates, PC

Demographic Information

First Name: _____ Middle: _____Last Name: _____
Birth Date: _____ Sex: M___ F ____ Social Security #: _____
Local Address: _____City: _____ State: _____ Zip: _____
Secondary Billing Address: (if applicable) _____
Home Phone #: _____ Work Phone #: _____ Cell Phone #: _____
Best Phone # to reach you: _____ May we leave a message? Yes ____ No____
Email: _____ Referring Physician: _____
Primary Care Physician: _____Occupation: _____
Emergency Contact: _____ Contact #: _____
Marital Status: _____Student Status: ☐ FT ☐ PT Smoker Status: Y N Veteran: Y N
Federal Standards require us to collect the following:
Preferred Language: _____
Please Choose One Ethnicity: Hispanic/Latino ____ Non-Hispanic/Latino ___Unknown ___Patient Refuse____
Please Choose One Race: Asian____ Black____ African American____ Greek ____ Indian ____
Multiracial____Unknown____White____ Other ____Patient Refused____

Insurance Information

Primary Insurance: _____ ID #: _____ Group #: _____
Insurance Company Address: _____Phone #: _____
Copay Amt: _____ Deductible: _____
Name of Policy Holder: _____ Relationship to Patient: _____
Policyholder SS#: _____ Policyholder DOB: _____

Secondary Insurance: _____ID #: _____ Group #: _____
Insurance Company Address: _____Phone #: _____
Copay Amt: _____ Deductible: _____
Name of Policy Holder: _____ Relationship to Patient:_____
Policyholder SS#: _____ Policyholder DOB: _____

The Receptionist Will Need to Make Copies Of Your Insurance Cards

Pharmacy Information:

Pharmacy Name: _____
Address: _____
City: _____ State:_____Zip:_____
Phone Number: _____Fax Number: _____

Mail Order Pharmacy Name: _____
Address: _____
City: _____ State: _____Zip:_____
Phone Number: _____Fax Number: _____

I verify the accuracy of the above information and authorize the release of information.

_____ _____ _____

Patient/Guardian Signature Date