

LEWISVILLE FAMILY PHYSICIANS

PATIENT INFORMATION

Last Name _____ First Name _____ MI _____: Male Female (Circle)

Address _____ City _____ State _____ Zip _____

DOB ___/___/___ SSN _____ Marital Status _____

Home Phone (_____) _____ Work Phone (_____) _____ Cell Phone (_____) _____

Place of Employment _____

Emergency Contact

Name _____ Home# _____ Work# _____ Cell# _____

Lewisville Family Physicians values their patients and we will take reasonable steps to maintain the confidentiality of patient's health information. Protected health information refers to individually identifiable information (including demographic information) relating to a person's health, to the healthcare provider to a person or to payment for healthcare. In effort to serve our patients, we are asking that you review and sign below indicating your preference of how we should provide you with any medical information that you should need which could include test/lab results or appointment/referral information.

Please list any names and telephone numbers that we may leave or discuss information with about your health care which could also include test/ lab results or appointment/referral information:

| Name | Relationship | Phone |
|----------|--------------|-------|
| 1. _____ | _____ | _____ |
| 2. _____ | _____ | _____ |
| 3. _____ | _____ | _____ |

Please initial that you have received a copy of the Protected Health Information Sheet _____

INSURANCE INFORMATION

Insurance Company _____ Plan Name / Type _____

Employer _____ Group Number _____ Policy Number _____

Policy Holder Name _____ Relation to patient _____

SSN of Policy Holder _____ Policy Holder's DOB _____

Secondary Insurance

Insurance Company _____ Plan Name / Type _____

Policy Holder Name _____ Relation to patient _____

Co Address _____ City _____ State _____ Zip _____

Lewisville Family Physicians will gladly submit you bill to your insurance company as a courtesy to you, however if we haven't received a response from them within 30 days of the billed date this bill will become your responsibility. All co pays and co insurance are due at time of service.

Patient
Signature _____ Date _____

Responsible Party _____ Date _____