

LAWRENCE FAMILY CARE AND PEDIATRICS

8501 E. 56TH STREET, SUITE 120
INDIANAPOLIS, INDIANA 46216
(317) 621-2360

PATIENT REGISTRATION INFORMATION

TODAY'S DATE: _____ NEW PATIENT: ESTABLISHED PATIENT:

HOW DID YOU HEAR ABOUT OUR PRACTICE? _____

PATIENT NAME: _____ LAST FIRST M.I.	HOME PHONE: _____
ADDRESS: _____ STREET APT. NO.	CELL PHONE: _____
_____ CITY STATE ZIP	EMPLOYER: _____
BIRTH DATE: _____ AGE: _____	WORK PHONE: _____ EXT: _____
SOCIAL SECURITY NO.: _____	OCCUPATION: _____
SEX: (CIRCLE ONE): M F	EMAIL: _____
MARITAL STATUS (CIRCLE ONE): SINGLE MARRIED DIVORCED WIDOWED	

PERSON RESPONSIBLE FOR PAYMENT: (If minor, person accompanying minor)						
(CIRCLE ONE)	SELF	SPOUSE	FATHER	MOTHER	EMPLOYER	OTHER
NAME: _____	HOME PHONE: _____					
ADDRESS: _____	CELL PHONE: _____					
_____	EMPLOYER: _____					
BIRTH DATE: _____ AGE: _____	WORK PHONE: _____ EXT.: _____					
SOCIAL SECURITY NO.: _____	OCCUPATION: _____					
EMAIL: _____						

IN CASE OF EMERGENCY CONTACT:

Name: _____ Home Phone: _____ Work Phone: _____

Address: _____

PATIENT'S ASSIGNMENT AND AUTHORIZATION TO RELEASE INFORMATION FOR PAYMENT:

To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize release of any information regarding services rendered and allow a photocopy of my signature to be used to file insurance and direct my insurer to issue payment for all medical surgical benefits, directly to the provider.

This assignment and authorization will remain in effect until revoked by me in writing.

I understand that I am financially responsible for the fees for all services rendered.

I have read the above and fully understand the terms thereof:

DATE

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY

MEDICARE ASSIGNMENTS OF BENEFITS AND AUTHORIZATION TO RELEASE INFORMATION

I, the undersigned, hereby authorize any holder of medical or other information about me to release to any insurance carrier and to the Social Security Administration, its intermediaries, carriers, or fiscal agents, any information needed for related MEDICARE claims. I permit this authorization to be used in place of the original, or the statement, "Signature on File", to be printed on claims to request payment of additional insurance benefits either to myself or to the party who accepts assignment of benefits.

PATIENT SIGNATURE

**Preventative services Data Sheet
Lawrence Family Care and Pediatrics**

Today's Date: _____

Name: _____ Date of Birth: _____

Age: _____ Weight: _____ Height: _____

Race: _____ Sex: _____ Marital status: S M D W

Occupation: _____

What is the main reason for your visit today? _____

Check any personal significant illness:

Heart Disease	YES NO
Lung Disease	YES NO
Liver Disease	YES NO
Gastrointestinal Disease	YES NO
High Blood Pressure	YES NO
Diabetes	YES NO
Stroke	YES NO
Bleeding Problems	YES NO
Cancer	YES NO
Other (list) _____	

Check any family history of illness:
(1st degree relative-parent, siblings
and children)

Heart Disease	YES NO
Lung Disease	YES NO
Liver Disease	YES NO
Gastrointestinal Disease	YES NO
High Blood Pressure	YES NO
Diabetes	YES NO
Stroke	YES NO
Bleeding Problems	YES NO
Cancer	YES NO
other (list) _____	

Allergies – All:

Do you smoke? YES NO How long? _____ How many packs per day? _____

On average, about how many alcoholic drinks do you consume each day? _____

How many children do you have? _____ Date of last menstrual period? _____

Childhood Illness: Mumps: _____ Measles: _____
Whooping cough: _____ Rheumatic fever: _____ Scarlet fever: _____
other: _____

Vaccinations/ Immunizations:

Tetanus Y N date: _____ Influenza Y N date: _____
Pneumonia Y N date: _____ Hepatitis Y N date: _____

Children's: (Please bring shot record)

Hepatitis B _____

Rotavirus _____

DTap (Diphtheria, Tetanus & Pertussis) _____

Polio _____

Pneumococcal _____

MMR (measles, mumps & rubella) _____

Vaicella (chicken pox) _____

Hepatitis A _____

Meningococcal _____

Problems List:

Surgery List with dates:
