

# 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	

<b>PERSON RESPONSIBLE FOR PAYMENT:</b> (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? \_\_\_\_\_

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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:  
(1<sup>st</sup> 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:

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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:**

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**Surgery List with dates:**

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