### **Lafayette Pediatrics and Internal Medicine**

## **Patient information**

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| --- |
| (Please Print) |
| PATIENT INFORMATION |
| **Patient’s last name:** | **First:** |  Middle:  |  |  | Today’s date: |
|  |  / / |
| Is this your legal name? | **If not, what is your legal name?** |  | **Birth date:** |  | **Sex:** |
| ❑ Yes | ❑ No |  |  |  / / |  | ❑ M | ❑ F |
| Email: | Please confirm appointments by: | **Main Phone:** |
|  | ❑ Home ❑ Cell ❑ Work ❑ Email | ( ) |
| **Home Street address:** | Cell Phone:( ) |
| **City:** |  | **State:** | **Zip Code:** | Work Phone: |
|  |  |  |  | ( ) |
| **Mailing address: (if different than above)** |  |  | Preferred pharmacy name and address: |
|  |  |  |  |
| **Primary Provider:** ❑ Adam Palazzari, MD | ❑ Maura Capaul, FNP |  |  |
| **How did you hear about us**?: ❑ Family ❑ Friend ❑ Insurance Plan ❑ Hospital ❑ Close to home/work ❑ Another Clinic ❑ Other Name of referring patient:  **Ethnicity**: ❑Hispanic/Latino ❑Not Hispanic/Latino ❑Refuse to Report  |
| **Race:** ❑Caucasian ❑Other Pacific Islander ❑More than one Race ❑Black/African American ❑ Alaskan Native ❑ Native American/American Indian  ❑Asian ❑European ❑Native Hawaiian ❑Other ❑Unknown ❑Refuse to Report |
| **Language:** ❑English ❑Spanish ❑French ❑German ❑Hindi ❑Italian ❑Russian ❑Japanese ❑ Portuguese ❑Refuse to Report |
| Additional INFORMATION |
| **Parent/Guardian:** | Birth date: | Sex: | Phone: |
|  |  / / | ❑ M ❑ F | ( ) |
| **Parent/Guardian:** | Birth date: | Sex: | Phone: |
|  |  / / | ❑ M ❑ F | ( ) |
| **Primary Caregiver:** | Relation to patient: |  | Phone: |
|  |  |  | ( ) |
| Other family members: |  | Birth date: | Sex: | Phone: |
|  |  |  / / | ❑ M ❑ F | ( ) |
|  |  | Birth date: | Sex: | Phone: |
|  |  |  / / | ❑ M ❑ F | ( ) |
|  |  | Birth date: | Sex: | Phone: |
|  |  |  / / | ❑ M ❑ F | ( ) |
|  |  | Birth date: | Sex: | Phone: |
|  |  |  / / | ❑ M ❑ F | ( ) |
| INSURANCE INFORMATION |
| (Please give your insurance card to the receptionist) |
| **Name of Primary Insurance:** | **Subscriber’s name:** | **Birth date:** | **Social Security #:** |  |
|  |  |  / / |  |  |
| IN CASE OF EMERGENCY |
| Name of friend or relative (not living at same address): | Relationship to patient: | Home phone: | Work / Cell phone: |
|  |  | ( ) | ( ) |
| The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Lafayette Pediatrics and Internal Medicine or insurance company to release any information required to process my claims. |
|  |  |  |  |  |
|  | **Patient/Guardian signature** |  | **Date** |  |