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

## **Patient information**

|  |
| --- |
| (Please Print) |
| PATIENT INFORMATION |
| **Patient’s (legal) last name:** | **First:** |  Middle:  |  |  | Today’s date: |
|  |  / / |
| **Preferred name:** |  | **Mother’s maiden name:** | **Birth date:** |  | **Sex:** |
|  |  |  |  |  / / |  |  |  |
| **Patient email (if applicable):** | **Preferred method of contact:** | **Consent to call/text:** |
|  | ❑ Home ❑ Cell ❑ Work ❑ Email ❑ Portal | ❑ Call ❑ Text  |
| **Home Street address:** | Home Phone:( ) |
| **City:** |  | **State:** | **Zip Code:** | Cell Phone: |
|  |  |  |  | ( ) |
| **Mailing address: (if different than above)** |  |  | Work Phone: |
|  |  |  | ( ) |
| **Primary Provider:** ❑ Adam Palazzari, MD | ❑ Maura Capaul, FNP | ❑ Heather Dunham, FNP |  |
| **Language:** ❑English ❑Spanish ❑French ❑German ❑Hindi ❑Italian ❑Russian ❑Japanese ❑ Portuguese ❑Refuse to Report   |
| **Race:** ❑White ❑Black/African American ❑ Alaskan Native/American Indian ❑Asian ❑Refuse to Report |
| **Ethnicity**: ❑Hispanic/Latino ❑Not Hispanic/Latino ❑Refuse to Report  |
| Additional INFORMATION |
| **Parent/Guardian:** | Birth date: | Sex: | Phone: |
|  |  / / |  | ( ) |
| **Parent/Guardian:** | Birth date: | Sex: | Phone: |
|  |  / / |  | ( ) |
| **Preferred Pharmacy:**  | Additional Info:  |  |  |
|  |  |  |  |
| Other family members: |  |  |  |  |
|  |   |  |  |  |
|  |  |  |  |  |
|  |  |   |  |  |
| INSURANCE INFORMATION |
| (Please give your insurance card to the receptionist) |
| **Name of Primary Insurance:** | Phone: | **Relation to patient:** |  |  **Birth date:** |
|  | ( ) |  |  |  / / |
| **Subscriber’s name:**  | **Guarantor Address:** |  |  |
|  |  |  |  |
| **Guarantor (Person the bills should go to):** |  | Guarantor Email: |  |  |
|  |  |   |  |  |
| 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** |  |