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

## **Patient information**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| (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: | | | | | | | | | |  | | | | | |  | | | | | | | |  | |  | | | | | | |
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| 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: | | | | | | | |  | |  | | | | | | |
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| 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. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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|  | **Patient/Guardian signature** | | | | | | | | | | | | | | | | | |  | | | **Date** | | | | | | | | | |  |