Lebanon HMA Physician Mgmt, LLC

NEW PATIENT INFORMATION SHEET

NAME: _____ **DATE OF BIRTH:** _____ **AGE:** ____
(Last Name) (First Name) (Middle Initial)

STREET ADDRESS: _____ **APT NO.:** _____

CITY: _____ **STATE:** _____ **ZIP CODE:** _____

TELEPHONE NO.:_____ **SPOUSES NAME:** _____

EMPLOYER: _____**Work-Phone**_____**Social Security Number :**_____

Gender: male_____**female**_____ **Martial Status:** Married ____ Single ____ Other _____

INSURANCE INFORMATION: *Please provide the front desk coordinator with your insurance card.*

Primary Insurance: _____ **Insured Name:** _____

Secondary Insurance: _____ **Insured Name:** _____

Other Coverage: _____ **Insured Name:** _____

Is this visit the result of an auto accident? _____ **Work injury?** _____ **Other:** _____

RESPONSIBLE PARTY INFORMATION:

NAME:_____ **RELATIONSHIP TO PATIENT:** _____

ADDRESS: _____ **TELEPHONE NO.:** _____

CITY: _____ **STATE:** _____ **ZIP CODE:** _____ **BIRTHDATE:** _____

EMPLOYER: _____**WORK TELEPHONE NO.:**_____

PREVIOUS PHYSICIAN: _____ **TELEPHONE NO.:** _____

ADVANCE DIRECTIVES: Yes_____ **No**_____ **I have an Advance Care Plan/Living Will**

Yes_____ **No**_____ **I would like a copy of an Advance Care Plan/Living Will**

HOW DID YOU HEAR ABOUT THE PRACTICE?: _____

EMERGENCY CONTACT *(PERSON NOT LIVING WITH YOU)* **:** _____**Relationship** _____
TELEPHONE NO.: _____

NAME OF PHARMACY _____**Phone**_____

SIGNATURE OF RESPONSIBLE PARTY:_____ **DATE:** _____