Lafayette Family Care

Patient Registration Form - PLEASE PRINT CLEARLY

Last Name: _____First: _____MI:_____

Date of Birth:_____/____/_____Social Security Number: _____-____-_____ ☐Female ☐ Male
Mailing Address/Street Number and Name :_____ Apt #:_____
City:_____ State:_____ Zip Code: _____

Physical Address: ☐ same as mailing address. If not, please fill in below:
Street Number and Name :_____ Apt #:_____
City:_____ State:_____ Zip Code: _____
Phone/Home: _____Work: _____ Cell: _____
E-mail Address:_____

How would you like to be contacted? ☐E-mail ☐Cell ☐Home Phone ☐Work Phone
Ethnicity: _____ Race: _____ Religion:_____
Language: _____ Education: _____ Occupation:_____

Employer: _____ ☐Not Employed ☐Retired
Employer Address: _____ Phone: _____
City: _____ State: _____ Zip Code: _____

Guarantor Information - Person Responsible for Payment ☐Self, if not self please fill in spaces below:
Last Name: _____First Name: _____ MI: _____

Date of Birth: _____ Relation to Patient: ☐ Spouse ☐ Parent ☐ Other:
Mailing Address: (If different than patient) _____

Home Phone Number: _____ Work Phone Number: _____

Emergency Contact Name: _____Relation to patient: _____
Phone/Home: _____Work: _____ Cell: _____
Primary Pharmacy Name: _____Phone:_____
Address:_____ Fax: _____

HOW DID YOU HEAR ABOUT LAFAYETTE FAMILY CARE? ❑ Newspaper ❑ Radio
❑ Postcard ❑ Brochure ❑ Website ❑ Insurance Listing ❑ Family or Friends ❑ Hospital:_____
❑ Referring Practitioner: _____ ❑ Other: _____

DOES THE PATIENT HAVE HEALTH INSURANCE?

☐ No. If patient is an adult please ask for a sliding scale application to see if you are eligible for discount based on your household income.

☐ No. If patient is a child, parent and guardian please ask for NH Healthy Kids assistance.

☐ Yes. Please fill out the information on next page:

PLEASE COMPLETE BOTH SIDES

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Patient Registration Form (CONTINUED)

HEALTH INSURANCE INFORMATION: (Please present all of your insurance cards to the check-in person)

Primary Insurance: _____ Subscriber Name: _____
ID # or Certificate #:_____ Subscriber SSN: _____-_____-_____
Group #:_____ Subscriber DOB: _____/_____/_____
Effective Dates: _____ Relation to Patient: _____

☐ Medicare #: _____ Print Name of Beneficiary: _____

☐ Medicaid/Healthy Kids #: _____ ☐ SeaCare #: _____

CONSENT FOR TREATMENT AT LAFAYETTE FAMILY CARE:
I do voluntarily consent to such diagnostic procedures and care deemed necessary by the provider, her assistant or designated consultants. I understand the practice of medicine is not an exact science and that no guarantees have been made to me as to the results of examination or treatment in this office. I understand that I retain the right to refuse any particular examination, test, procedure, treatment, therapy or medication recommended or deemed necessary by the provider.

PAYMENT OF BENEFITS AND INFORMATION RELEASE:
I hereby authorize medical benefits which I am entitled, including Medicare, Medicaid, private insurance companies or other health care plans to Lafayette Family Care for services furnished to me. I authorize to release my protected health information about me to the Social Security Administration, my insurance company or other health care agents for payment. This payment authorization is to be completed, signed by the beneficiary and retained in the files of the provider for service. It is valid for any service Lafayette Family Care provides to the beneficiary during his/her lifetime, unless revoked. A photocopy of this consent shall be considered as valid as the original.

NOTICE OF PRIVACY PRACTICES:
I acknowledge that I have been given the opportunity to receive a copy of Lafayette Family Care's Notice of Privacy Practices.

I have read, and fully understand the above information and consent fully and voluntarily to its contents. I have been afforded the opportunity to have any questions I might have addressed.

Patient Signature: _____ Date:_____

Responsible Party Signature and Relationship: _____ Date:_____