

Laramie Physicians for Women and Children

PATIENT INFORMATION

Today's Date:

First Name		Last Name		Date of Birth
Address		City	State	Zip Code
Mailing Address			Social Security Number	
Primary Phone		Work Phone		Cell Phone
Gender M F	Marital Status		Patient Employer (if applicable)	
Spouse's Name (if applicable)			Spouse's SSN (if applicable)	
Email Address of patient or parent				Referring Physician

Other Information

Patient's Primary Language: English Spanish Arabic Other				
Patient's Ethnicity: Hispanic/Latino Not Hispanic/Latino Decline to Answer				
Patient's Race: Asian Black/African American Native American/Alaskan Native Native Hawaiian/ other Pacific Islander White Other Decline to Answer				

Insurance Information

Primary Insurance		Policy #		
Policy Holder Name			Gender M F	Date of Birth
Insured Relationship to Patient Self Spouse Parent Other: _____				
Secondary Insurance		Policy #		
Policy Holder Name			Gender M F	Date of Birth
Insured Relationship to Patient Self Spouse Parent Other: _____				

Pediatric Patients

Please complete the following information

Mother's Information

First Name		Last Name		Patient's Guarantor? Yes No
Date of Birth	Soc Sec Number		Spouse's Name	
Full Address				
Home Phone		Work Phone		Cell Phone
Employer				

Father's Information

First Name		Last Name		Patient's Guarantor? Yes No
Date of Birth	Soc Sec Number		Spouse's Name	
Full Address				
Home Phone		Work Phone		Cell Phone
Employer				

Please complete additional information on back of form



Approved Contacts

EMERGENCY CONTACT	
Name:	Daytime Phone Number:

I authorize the following related to my *appointments* with LPWC:

Messages with my appointment dates/times may be left on my home and/or cell voice mail Yes No

Messages with my appointment dates/times may be left with _____ (provide name of approved individual) at this number _____.

Signature: _____

I authorize the following related to my *lab / test results* with LPWC:

Messages with my lab / test results may be left on my home and/or cell voice mail Yes No

Messages with my lab / test results may be left with _____ (provide name of approved individual) at this number _____.

Signature: _____

I authorize the following related to my *financial information* with LPWC:

Information regarding my financial information with LPWC may be discussed with _____ (provide name of individual).

Signature: _____

.....

How did you hear about our practice?

Phone Book

Friend/Family

Internet/Website

Newspaper

Radio (Y95 or IMiX)

Other: _____