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