LOURDES MEDICAL ASSOCIATES

PATIENT REGISTRATION

PLEASE MAKE SURE TO COPY INSURANCE CARDS and DRIVERS LICENSE

Last Name	**First Name**	**Middle Initial**	
Social Security	**Date of Birth**	**Sex:** ☐ F ☐ M	
Address	**City**	**State**	**Zip**

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Other Race ☐ Patient Declined	**Preferred Language:** ☐ English ☐ Spanish; Castilian ☐ Other: _____ **Ethnicity:** ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Patient Declined	**Marital Status:** ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated ☐ Partner

Occupation

Home Phone	**Do you have a legal guardian?** ☐ Yes ☐ No	**Legal Guardian Name**
Cell Phone	**Legal Guardian Address**	**Legal Guardian Phone**
Work Phone	**Emergency Contact Name**	**Emergency Contact Relationship**
Email	**Emergency Contact Address**	**Emergency Contact Phone**
Check Preferred Communication: ☐ Mail ☐ Home Ph ☐ Cell Ph ☐ Work Ph ☐ Email	Do you have an Advance Directive? ☐ No ☐ Yes Would you like an Advance Directive packet? ☐ No ☐ Yes	

Employer Name	**Employer Address**		
Employer Phone	**City**	**State**	**Zip**

Primary Care Physician:

Are you visually impaired? ☐ Yes ☐ No **Describe if Yes** _____

Are you hearing impaired? ☐ Yes ☐ No **Describe if Yes** _____

Translation service requested? ☐ Yes ☐ No **List language if Yes** _____

Reason for Visit:

How did you hear about Lourdes Medical Associates?

☐ Referred by LMA Physician	☐ LMA Website	☐ Burlington County Times
☐ Referred by NON-LMA Physician	☐ LHS Website	☐ Register News
Physician Name: _____	☐ Radio	☐ Central Record
☐ Friend / Family Member: _____	☐ TV	☐ Courier Post
☐ Insurance Company: _____	☐ Billboard	☐ Other newspaper _____

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Last Name	First Name	Date of Birth

Primary Pharmacy Name	Pharmacy Address		
Primary Pharmacy Phone	City	State	Zip
Secondary Pharmacy Name	Pharmacy Address		
Secondary Pharmacy Phone	City	State	Zip

PRIMARY INSURANCE: (please attach copies of cards and necessary referrals)

Insurance Address	City	State	Zip	Insurance Phone / Policy ID # / Group #
Subscriber Name	Subscriber Phone	Subscriber Employer	Employer Phone	
Subscriber Address		Employer Address		
City	State / Zip	City	State / Zip	
Date of Birth / Sex:	Subscriber Social Security	Employment Status		

Subscriber Relation to Patient

☐ Self ☐ Spouse ☐ Father ☐ Mother ☐ Life Partner

Employment Status

☐ Full Time ☐ Not Employed ☐ Retired
☐ Part Time ☐ Self Employed ☐ Active Military Duty
☐ Unknown

SECONDARY INSURANCE: (please attach copies of cards and necessary referrals)

Insurance Address	City	State	Zip	Insurance Phone / Policy ID # / Group #
Subscriber Name	Subscriber Phone	Subscriber Employer	Employer Phone	
Subscriber Address		Employer Address		
City	State / Zip	City	State / Zip	
Date of Birth / Sex:	Subscriber Social Security	Employment Status		

Subscriber Relation to Patient

☐ Self ☐ Spouse ☐ Father ☐ Mother ☐ Life Partner

Employment Status

☐ Full Time ☐ Not Employed ☐ Retired
☐ Part Time ☐ Self Employed ☐ Active Military Duty
☐ Unknown

I authorize the release of any medical or other information necessary to process this claim. I request payment of government benefits or payments from insurance company for physician services to be made directly to Lourdes Medical Associates and/or OLOLMC for the services rendered. I permit a copy of this authorization to be used in place of the original. I understand I am financially responsible for any balance not covered by my insurance.

I understand the cost of administrative forms is not covered under my insurance and I agree to be responsible for these charges. _____

I understand that I will be responsible for a $25 fee for non-cancellation of a scheduled appointment. _____

Patient Signature _____