



PLEASE MAKE SURE TO COPY INSURANCE CARDS and DRIVERS LICENSE

Last Name		First Name		Middle Initial	
Social Security		Date of Birth		Birth Sex <input type="checkbox"/> F <input type="checkbox"/> M	
Current Gender <input type="checkbox"/> F <input type="checkbox"/> M		Gender Identity		Sexual Orientation	
Address		City		State	Zip
Race: <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other Race <input type="checkbox"/> Patient Declined		Preferred Language: <input type="checkbox"/> English <input type="checkbox"/> Spanish; Castilian <input type="checkbox"/> Other: _____ Ethnicity: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Patient Declined		Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Partner	
Occupation					
Home Phone		Do you have a legal guardian? <input type="checkbox"/> Yes <input type="checkbox"/> 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: <input type="checkbox"/> Mail <input type="checkbox"/> Home Ph <input type="checkbox"/> Cell Ph <input type="checkbox"/> Work Ph <input type="checkbox"/> Email		Do you have an Advance Directive? <input type="checkbox"/> No <input type="checkbox"/> Yes Would you like an Advance Directive packet? <input type="checkbox"/> No <input type="checkbox"/> Yes			
Employer Name		Employer Address			
Employer Phone		City		State	Zip

Primary Care Physician:	
Are you visually impaired? <input type="checkbox"/> Yes <input type="checkbox"/> No Describe if Yes _____	
Are you hearing impaired? <input type="checkbox"/> Yes <input type="checkbox"/> No Describe if Yes _____	
Translation service requested? <input type="checkbox"/> Yes <input type="checkbox"/> No List language if Yes _____	
Reason for Visit:	

How did you hear about Lourdes Medical Associates?		
<input type="checkbox"/> Referred by LMA Physician	<input type="checkbox"/> LMA Website	<input type="checkbox"/> Burlington County Times
<input type="checkbox"/> Referred by NON-LMA Physician	<input type="checkbox"/> LHS Website	<input type="checkbox"/> Register News
Physician Name: _____	<input type="checkbox"/> Radio	<input type="checkbox"/> Central Record
<input type="checkbox"/> Friend / Family Member: _____	<input type="checkbox"/> TV	<input type="checkbox"/> Courier Post
<input type="checkbox"/> Insurance Company: _____	<input type="checkbox"/> Billboard	<input type="checkbox"/> Other newspaper/ publication
	<input type="checkbox"/> Twitter/ Facebook	_____

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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 Phone		Policy ID #	
Insurance Address			City	State	Zip	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				<input type="checkbox"/> Full Time <input type="checkbox"/> Not Employed <input type="checkbox"/> Retired <input type="checkbox"/> Part Time <input type="checkbox"/> Self Employed <input type="checkbox"/> Active Military Duty <input type="checkbox"/> Unknown			
<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Life Partner							

SECONDARY INSURANCE: (please attach copies of cards and necessary referrals)				Insurance Phone		Policy ID #	
Insurance Address			City	State	Zip	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				<input type="checkbox"/> Full Time <input type="checkbox"/> Not Employed <input type="checkbox"/> Retired <input type="checkbox"/> Part Time <input type="checkbox"/> Self Employed <input type="checkbox"/> Active Military Duty <input type="checkbox"/> Unknown			
<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Life Partner							

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 _____