John A Llauget, LHMC

REGISTRATION FORM

(Please Print Legibly)

Today's Date	PCP	PCP Phone

PATIENT INFORMATION

Last Name	First Name	Middle	Date of Birth	Sex M / F

Street Address/PO Box	Mailing Address (if different from Street Address)	Pt Relationship to Insured Self / Spouse / Child / Other

City	State	Zip	City	State	Zip	Marital Status Single / Mar / Div / Sep / Wid

Home Phone	Cell Phone	Work Phone	Pt Employment Status Employed / FT Student / PT Student

Social Security #	E-mail Address	Referred By

Emergency Contact	Home Phone	Cell Phone

Employer/School	Employer Phone	

INSURANCE INFORMATION

Insurance Company	Member/Subscriber ID #	Group #

Claims Address

Insured Last Name (or "SELF")	First Name	Middle	Date of Birth	Social Security #

Insured Street Address	City/State	Zip	Phone

Insured Employer	Employer Address	Employer Phone

Terms of Confidentiality and Disclosure are addressed in the **Notice of Privacy Practices** and **Limits of Confidentiality** which have been provided, reviewed and completed as required.

Consent to Treatment and assignment of financial responsibility for services rendered are addressed in the **Information and Introduction to Services** and **Financial Policy** documents which have been reviewed and completed as required.

I understand that it is my responsibility to notify my Provider of any changes to any of the information provided in this document or the documents referenced above, prior to services being rendered.

_____ _____

Client/Authorized Signature **Date**

(112911)