West Jefferson Medical Center LCMC Health	**PATIENT INFORMATION** PAGE 1 OF 1	*PATIENT INFORMATION* PLACE PATIENT'S LABEL HERE

PATIENT INFORMATION – Please Print

Patient Name _____
Last First Middle

Sex: ❑M ❑ F Date of Birth _____ Social Security # _____

Address _____ Apt. _____

City _____ State _____ Zip _____

Home Phone _____ Mobile _____

E-mail _____

Employer _____ Work Phone _____

Please check one: ❑ Married ❑Single ❑ Partner ❑ Divorced ❑ Widowed ❑ Separated

PARENT (if minor) INFORMATION

Name _____ Date of Birth _____

Social Security _____ E-mail _____@_____.____

Employer _____ Address _____ Phone _____

INSURANCE POLICY HOLDER INFORMATION

Name _____ Date of Birth _____

Social Security _____ E-mail _____@_____.____

Employer _____ Address _____ Phone _____

PERSON RESPONSIBLE FOR PAYMENT

❑ Patient

Responsible Party _____ DOB _____

Relation to patient _____ Social Security _____ Phone _____

Address _____ City _____ State _____ Zip _____

REFERRAL

If you are a new patient, how did you hear about the clinic or physician?

01 ❑ Recommended by friend or family member
02 ❑ Referred by a Physician _____
03 ❑ Hospital Directory / Yellow Pages
04 ❑ Insurance Plan Directory
05 ❑ Employer
06 ❑ Community or Company Health Fair
07 ❑ Newspaper or Magazine
08 ❑ Internet or clinic web site
09 ❑ Drove by clinic / Location of clinic
10 ❑ Other Source: Please list _____
11 ❑ Treated by physician in the hospital
12 ❑ Return Patient/ Not applicable