Lifetime Family Care, PLLC

Date_____

Name_____
(LAST NAME) (FIRST NAME)

Address _____

City _____State_____Zip_____

Date of Birth _____Social Security_____ Phone_____

Age_____Gender_____Referred By_____

Martial Status: Married / Single / Widowed / Divorced / Separated

Race/Ethnic: American Indian /Alaska Native / Asian / African American / Hispanic / Native Hawaiian / Other Pacific Islander / Caucasian / Others _____

Primary Language used: _____

Type of Insurance_____
(Please Attach Insurance Card and Picture I.D.)

Subscriber Name_____ Subscriber's Birthday_____

Occupation_____Employer_____

Address_____Phone_____

Emergency Contact_____
(Not the same address and phone as your own please)

Relationship_____Phone_____

Spouse
Name_____Employer_____
(Or Parent - if patient is a minor)

I allow my Insurance Company to be billed for all applicable services and I agree to be responsible for any DEDUCTIBLES, CO-PAYMENTS, or services not covered, as dictated by my insurance company.

X_____(SIGNATURE)