Lake Village Clinic

PATIENT INFORMATION

The Lake Village Clinic will need the following information and it is very important that you bring.

1. All Health Insurance Cards including Medicare, Medicaid and Social Security Card.
2. All medicines you are currently taking.
3. Picture of yourself we can keep for you medical record.

PREFERRED DRUG STORE NAME____________________________ LOCATION:______________________

NAME____MAIDEN NAME__________________

(LAST) (FIRST) (MI)

SS#__________________________________SEX___________DATE OF BIRTH_________________________

MARITAL STATUS_______________RACE (CIRCLE ONE)_CAUCASIAN AFRICAN AMERICAN HISPANIC OTHER:________

STREET ADDRESS__________________________CITY______________STATE_________ZIP__________

MAILING ADDRESS__________________________CITY______________STATE_________ZIP_________

HOME PHONE_______________________CELL OR ALTERNATIVE PHONE_________________________

PLACE OF EMPLOYMENT ___________________________OCCUPATION___________________________

EMPLOYMENT ADDRESS____________________CITY______________STATE__________ZIP_________

WORK PHONE____

EMAIL ADDRESS ____

GUARANTOR INFORMATION

PERSON RESPONSIBLE FOR BILL_________________________________SS#_________________________

RELATIONSHIP TO PATIENT_____________________________________SEX________________________

ADDRESS______________________________CITY_______________STATE____________ZIP__________

EMPLOYER____WORK PHONE_______________________

Lake Village Clinic, 2918 Louis Session St. Lake Village, AR 71653
Phone: (870) 265-5345 Fax: (870) 265-5686
www.LakeVillageClinic.com

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AUTHORIZATION OF MEDICARE, MEDICAID AND INSURANCE BENEFITS

I hereby authorize direct payment of surgical/medical benefits to Lake Village Clinic, for services rendered by him/her in person or under his/her supervision. I understand that I am financially responsible for any balance not covered by my insurance. I certify that the information given by me in applying for payment is correct. I authorize release of all records on request. I request that payment of authorization benefits be made on my behalf.

A photocopy of these assignments shall be valid as the original.

AUTHORIZATION OF RELEASE OF INFORMATION

I hereby authorize Lake Village Clinic to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefit.

EMERGENCY CONTACT INFORMATION

Name of relative not living with you____________________________PHONE:_________________________

I hereby give consent to the Lake Village Clinic to render any treatment they deem necessary for my well-being.

Patient/Guardian____

Please Print

Patient/Guardian_____________________________ _______________

Signature Date

THE LAKE VILLAGE CLINIC
Receipt of Notice of Privacy Practices
Written Acknowledgment Form

I, ___________________________ have received a copy of Lake Village Clinic Notice of Privacy Practices.

Patient Name

______________________________ _________________

Patient Signature Date

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