LAST name: Date:

FIRST name:

Middle Initial:

DOB:

Street Address:

Zip Code:

City:

State:

Sex: \_\_\_\_\_Male \_\_\_\_\_Female

Home phone:

Mobile phone:

Consent to text: \_\_\_\_\_Yes \_\_\_\_\_No

Email:

Contact preference: \_\_\_\_\_Home \_\_\_\_\_Cell

Marital status: \_\_\_\_\_Single \_\_\_\_\_Married

**Insurances:**

Primary: Name of Health Insurance Plan:

 Relationship to Insured: (circle) Self Spouse Child Other

 If **not** self, Insured’s Name: DOB:

Secondary: Name of Health Insurance Plan:

 Relationship to Insured: (circle) Self Spouse Child Other

 If **not** self, Insured’s Name: DOB:

**Privacy:**

Consent to medical record sharing per HIPAA regulations: \_\_\_\_\_\_\_Yes \_\_\_\_\_\_\_\_No

Consent to call: \_\_\_\_\_\_\_Yes \_\_\_\_\_\_\_\_No

Informed of Notice of Privacy Policy: \_\_\_\_\_\_\_Yes \_\_\_\_\_\_\_\_No

Legally it is required that we ask for the following information, but you are allowed to leave it blank.

 Language:

 Race:

 Ethnicity:

**PLEASE SIGN: To the best of my knowledge the above information is complete and accurate.**

I hereby authorize Dr. Lussier to furnish information to insurance carriers concerning my illness and treatment, and I hereby assign all payments for medical services rendered to me or to my dependents to be paid directly to Dr. Lussier. I understand that I am responsible for any amount not covered by my insurance. If after sixty (60) days payment has not been received by Dr. Lussier, then full payment is due and payable by me.

Patient Signature Date: