LAKELAND
PRIMARY CARE CLINIC, PLLC

Lakeland Primary Care Clinic, PLLC
1040 River Oaks Drive, Ste 301
Flowood, MS 39232

PATIENT REGISTRATION FORM
(Please answer all questions)

PATIENT INFORMATION:

Patient's Name:_____ Social Security Number:_____

Address:_____ City:_____ State:_____ Zip:_____

Employer:_____ Address:_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Birth Date:_____ Sex:_____ Marital Status:_____

Spouse's Name:_____ Spouse's DOB:_____

Spouse's Employer:_____ Spouse's Work Phone:_____

Alternate Contact Person (friend or relative who can reach you at all times):_____

Relation to patient:_____ Phone:_____

PERSON RESPONSIBLE FOR BILL (if different from the patient):

Guarantor's Name:_____ Social Security Number:_____

Address:_____ City:_____ State:_____ Zip:_____

Employer:_____ Address:_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

INSURANCE INFORMATION (please present insurance card(s) and photo ID to receptionist):

Primary Insurance Company:_____

Address:_____

Insured Name:_____ Relation:_____ DOB:_____ SS#:_____

Policy Number:_____ Group Number:_____

Secondary Insurance Company:_____

Address:_____

Insured Name:_____ Relation:_____ DOB:_____ SS#:_____

Policy Number:_____ Group Number:_____

REFERRAL: Referred to our clinic by _____

Authorization for treatment, release of information, and assignment of insurance benefits:

I authorize Dr. Thomas Emile LaGarde to furnish medical treatment by those means he considers necessary and proper in the treatment of the person identified below while a patient of Lakeland Primary Care Clinic, PLLC. This treatment may require diagnostic procedures including, but not limited to, laboratory tests, blood drawing for those tests, x-rays and electrocardiograms. I request that payment of authorized Medicare, Medicaid, or other third party insurance be made to Lakeland Primary Care Clinic, PLLC if assignment is accepted, in which case I do agree to pay any deductible, co-payment or charges not covered by this authorization. I authorize Lakeland Primary Care Clinic, PLLC or my attending physician to release to the Centers for Medicare and Medicaid Services and its agents, or the Division of Medicaid, or their Fiscal Agent, or any third party insurance company any information needed to determine these benefits. I authorize Lakeland Primary Care Clinic, PLLC to retire x-ray films or any other graphic data four years after they are generated if a proper report is in the health record. For services rendered to the patient named below, I, the undersigned, agree to pay all professional, outpatient and/or hospital visit charges not covered by insurance. I also agree to pay reasonable attorney and/or collection fees necessary for the collection of payment. The term of this Consent for Treatment shall be valid until either party gives written notice of its termination. A copy of this agreement is as valid as the original.

_____ _____ _____

Patient Name | Signature of Patient/Guardian | Date