

For Staff Use Only:

Date:	Patient Number:	PJ DW KC LW EW MN CR
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## LITCHFIELD FAMILY PRACTICE CENTER

<b>PATIENT INFORMATION (PLEASE PRINT)</b>									
Patient's Last Name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Miss <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.	Marital Status:			<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed	
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?		Former/Maiden Name:		Birth Date: / /		Sex: <input type="checkbox"/> M <input type="checkbox"/> F		
Street Address:			PO Box:		Home # ( )				
					Cell # ( )				
City:			State:		Zip Code:		SSN:		
Employer:		Employer City and State:			Work # ( )				
					Other # ( )				
Preferred Communication: <input type="checkbox"/> Mail <input type="checkbox"/> Email <input type="checkbox"/> Phone <input type="checkbox"/> Web Message				Email:				<input type="checkbox"/> Refused to Report	
Race:	<input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> African American <input type="checkbox"/> More than one Race <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Refused to Report								
Ethnicity: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Refused to Report					Spoken Language:				
<b>RESPONSIBLE PARTY INFORMATION</b>									
<input type="checkbox"/> Check if same as above									
Last Name:		First:	Middle:	Birth Date: / /		Relationship:			
Street Address:			PO Box:		Home # / /				
					Cell # ( )				
City:			State:		Zip Code:		SSN:		
Employer:		Employer City and State:			Work # ( )				
					Other # ( )				
<b>IN CASE OF EMERGENCY</b>									
Last Name:		First:	Middle:	Home # ( )		Relationship:			
				Other # ( )					
<b>ADDITIONAL CONTACT INFORMATION</b>									
Last Name:		First:	Middle:	Home # ( )		Relationship:			
				Other # ( )					

**Continue On Back**

**PLEASE GIVE YOUR INSURANCE CARD  
AND DRIVERS LICENSE OR PHOTO ID TO THE RECEPTIONIST**

**PRIMARY INSURANCE INFORMATION**

<input type="checkbox"/> None	<input type="checkbox"/> Medicaid	<input type="checkbox"/> Medicare	<input type="checkbox"/> Other (Please List)		
<b>Who is responsible for this insurance policy?</b>					
Name:	SSN:	Birth Date: / /	Group #:	Policy/Member ID#:	Co-payment: \$
Is this person a patient here?	<input type="checkbox"/> Yes	Address:		Home # ( )	
	<input type="checkbox"/> No			Cell # ( )	
Employer:	Employer City and State:		Work # ( )		
			Other # ( )		
Patient's relationship to subscriber:	<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other (Please List)	

**SECONDARY INSURANCE INFORMATION**

<input type="checkbox"/> None	<input type="checkbox"/> Medicaid	<input type="checkbox"/> Medicare	<input type="checkbox"/> Other (Please List)		
<b>Who is responsible for this insurance policy?</b>					
Name:	SSN:	Birth Date: / /	Group #:	Policy/Member ID#:	Co-payment: \$
Is this person a patient here?	<input type="checkbox"/> Yes	Address:		Home # ( )	
	<input type="checkbox"/> No			Cell # ( )	
Employer:	Employer City and State:		Work # ( )		
			Other # ( )		
Patient's relationship to subscriber:	<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other (Please List)	

Keeping your appointment time is important not only to your health, but also to the other patients who require treatment. We understand that conflicts arise and request you give us at least 24 hours' notice when canceling an appointment. To prevent patients from scheduling appointments and not showing up for them, leaving gaps in our schedules that could have accommodated other patients, the following policy went into effect January 1, 2006:

*If you fail to give at least a 24-hour cancellation notice to us, a "No Show" charge may be applied to your account. You will be allowed to reschedule after that charge is paid in full. Please respect the time set aside for your appointment and let us know if for some reason you must reschedule. To cancel an appointment, please call your physician's nursing staff at (217) 324-6127.*

I certify the above information is true to the best of my knowledge. I authorize Litchfield Family Practice Center and my insurance to release any information required to process my claims and authorize that insurance benefits be paid directly to the physician.

I understand that I am financially responsible for any balance on my account. In the event I fail to pay charges that remain after insurance, I understand that I am responsible for all costs associated with resolving my account including, but not limited to, collection agency fees equal to 25% of my outstanding balance plus attorney fees.

I consent to medical treatment at Litchfield Family Practice Center, LLP. I understand I have the right to refuse any procedure or treatment and I have the right to discuss all medical treatments with my clinician.

\_\_\_\_\_  
Patient/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_ Time