For Staff Use Only:

Date:	Patient Number:	JJE RAW PWJ TLI AEF DAW KAC LJW

LITCHFIELD FAMILY PRACTICE CENTER

PATIENT INFORMATION
(PLEASE PRINT)

Patient's Last Name:	First:	Middle:	❑ Mr. ❑ Miss ❑ Mrs. ❑ Ms.	Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	Former/Maiden Name:	Birth Date: / /	Sex: ❑ M ❑ F

Street Address:	PO Box:	Home # ( )
		Cell # ( )

City:	State:	Zip Code:	SSN:

Employer:	Employer City and State:	Work # ( )
		Other # ( )

Preferred Communication: ❑ Mail ❑ Phone ❑ Web Message	Email: ❑ Refused to Report

Race:	❑American Indian or Alaska Native ❑Asian ❑African American ❑More than one Race ❑Native Hawaiian ❑Other Pacific Islander ❑White ❑Refused to Report

Ethnicity: ❑Hispanic or Latino ❑Not Hispanic or Latino ❑Refused to Report	Spoken Language:

Other family members seen here:

RESPONSIBLE PARTY INFORMATION

❑ Check if same as above

Last Name:	First:	Middle:	❑ Mr. ❑ Miss ❑ Mrs. ❑ Ms.	Relationship:

Street Address:	PO Box:	Home # ( )
		Cell # ( )

City:	State:	Zip Code:	SSN:

Employer:	Employer City and State:	Work # ( )
		Other # ( )

ADDITIONAL CONTACT INFORMATION

Last Name:	First:	Middle:	Home # ( )	Relationship:
			Other # ( )	

IN CASE OF EMERGENCY

(Name of local friend or relative not living at same address)

Last Name:	First:	Middle:	Home # ( )	Relationship:
			Other # ( )	

OTHER PEOPLE LIVING IN YOUR HOME

Name:	Relationship:
Name:	Relationship:
Name:	Relationship:
Name:	Relationship:

PLEASE GIVE YOUR INSURANCE CARD

AND DRIVERS LICENSE OR PHOTO ID TO THE RECEPTIONIST.

PRIMARY INSURANCE INFORMATION

❑ None	❑ Medicaid	❑ Medicare	❑ Other (Please List)

Who is responsible for this insurance policy?

Name:	SSN:	Birth Date: / /	Group #:	Policy/Member ID#:	Co-payment: $
Is this person a patient here? ❑ Yes ❑ No	Address:			Home # ( )	
				Cell # ( )	
Employer:	Employer City and State:			Work # ( )	
				Other # ( )	

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other (Please List)

SECONDARY INSURANCE INFORMATION

❑ None	❑ Medicaid	❑ Medicare	❑ Other (Please List)

Who is responsible for this insurance policy?

Name:	SSN:	Birth Date: / /	Group #:	Policy/Member ID#:	Co-payment: $
Is this person a patient here? ❑ Yes ❑ No	Address:			Home # ( )	
				Cell # ( )	
Employer:	Employer City and State:			Work # ( )	
				Other # ( )	

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ 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. In order 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 have to 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.

_____ _____

Patient/Guardian Signature *Date*