LEBANON FAMILY HEALTH SERVICES
PATIENT INFORMATION

PATIENT#_____ DATE_____

NAME_____
(last) (middle initial) (first)

ADDRESS_____

CITY_____ STATE_____ ZIP_____

IS IT OKAY TO SEND MAIL TO THIS ADDRESS?	*YES*	*NO*

PHONE NUMBERS:		Is it ok to call this number?		Leave a message?	
1 _____Home_____	(_____) _____-_____	yes	no	yes	no
2 _____Cell_____	(_____) _____-_____	yes	no	yes	no

IS IT OKAY TO CALL THESE PHONE NUMBERS?	*YES*	*NO*

EMAIL ADDRESS _____

IS IT OKAY TO SEND INFORMATION TO THIS EMAIL ADDRESS?	*YES*	*NO*

SOCIAL SECURITY NUMBER_____ -- _____ -- _____

DATE OF BIRTH_____ **AGE**_____ **RACE**_____

MARITAL STATUS ___**single** ___**married** ___**separated** ___**divorced** ___**widowed**

EMPLOYMENT ___**full time** ___**part time** ___**not employed**

STUDENT STATUS ____**full time** ____**part time** ____**not a student**

How Many People in your household: _____

Total Annual Income for everyone in household : **$**_____

EMERGENCY CONTACT NUMBER (list the name and number of a friend or family member that you would like us to contact in case of a **medical emergency ONLY**)

Name_____ **Number**_____

ALTERNATIVE CONTACT NUMBER (list a name and telephone number of a friend or family member that we may contact in case we are unable to reach you for any reason)

Name_____ **Number**_____

I authorize the release of any medical or other information necessary to prove an insurance claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

_____ _____
PATIENT SIGNATURE DATE

ktd 9/13