Lamoine Valley Clinic Patient Data Form

Thank you for choosing Lamoine Valley Clinic for your health care needs. Please complete the information below before your visit to our office. This will help us to minimize your waiting time.

Personal Information

Name ______________________________ Birthdate ______________
(Last) (First) (Middle) (MM/DD/YYYY)

Address ____
(Street) (City) (State) (Zip)

E-Mail Address ______________________________

Home Phone ______________

Social Security Number ______________ Marital Status ______________

Spouse Name ______________________ Spouse Work Phone ______________

Insurance Information

Employer Name ______________________________ Phone ______________

Employer Address ____
(Street) (City) (State) (Zip)

Policy Holders Name ______________ Policy Holders Date of Birth ______________

Primary Insurance ______________ Policy Number ________ Group Number ________

Secondary Insurance ______________ Policy Number ________ Group Number ________

Medical Information

Have you ever been told you have…		*Have you ever had surgery?*	
Diabetes	Y / N	Tonsillectomy	Y / N
High Blood Pressure	Y / N	Gallbladder	Y / N
High Cholesterol	Y / N	Appendix	Y / N
Heart Problems	Y / N	Colon	Y / N
Cancer	Y / N	Hernia	Y / N
Asthma	Y / N	Hysterectomy	Y / N
Seizures	Y / N	Were your ovaries removed?	Y / N
Tuberculosis	Y / N		
Thyroid problems	Y / N		
Liver Problems	Y / N		
Kidney Problems	Y / N		

Please list your allergies to medications ______________________________
____

Current Medications

______________ ______________ ______________
______________ ______________ ______________
______________ ______________ ______________

I hereby authorize payment of benefits, due to me, to be made directly to Lamoine Valley Clinic, S.C. I understand that I am and remain financially responsible for these charges. I authorize the Lamoine Valley Clinic, S.C. to release any information acquired in the course of examination or treatment and allow a photocopy of my signature to be used for this purpose.

____
Signature of patient or legal guardian