

**J. David Lackey, M.D.**  
PATIENT INFORMATION

PLEASE PRINT CLEARLY

DATE \_\_\_\_\_

NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ AGE \_\_\_\_\_

MAILING ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

SOCIAL SECURITY # \_\_\_\_\_ MARITAL STATUS \_\_\_\_\_ HOME PHONE \_\_\_\_\_

EMPLOYER \_\_\_\_\_ POSITION \_\_\_\_\_ WORK PHONE \_\_\_\_\_

SPOUSE (If a Minor please name RESPONSIBLE PARTY: i.e. Parent) \_\_\_\_\_

MAILING ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_ SOCIAL SECURITY # \_\_\_\_\_ HOME PHONE \_\_\_\_\_

EMPLOYER \_\_\_\_\_ POSITION \_\_\_\_\_ WORK PHONE \_\_\_\_\_

PRIMARY MEDICAL INS. \_\_\_\_\_ NAME OF POLICY HOLDER \_\_\_\_\_

INS. CO. MAILING ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

ID# / POL # \_\_\_\_\_ GROUP ID# \_\_\_\_\_

INS. CO, PHONE# \_\_\_\_\_ PRE-CERTIFICATION PHONE # \_\_\_\_\_

SECONDARY MEDICAL INS. \_\_\_\_\_ NAME OF POLICY HOLDER \_\_\_\_\_

INS. CO. MAILING ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

ID# / POL # \_\_\_\_\_ GROUP ID# \_\_\_\_\_

INS. CO, PHONE# \_\_\_\_\_ PRE-CERTIFICATION PHONE # \_\_\_\_\_

PERSON WHO DOES NOT LIVE WITH YOU TO CONTACT IN CASE OF EMERGENCY:

NAME \_\_\_\_\_ HOME PHONE \_\_\_\_\_ WORK PHONE \_\_\_\_\_

WHO REFERRED YOU TO OUR PRACTICE?

WHY HAVE YOU COME TO SEE US?

ARE YOU ALLERGIC TO ANY MEDICATIONS OR FOODS? YES \_\_\_\_\_ NO \_\_\_\_\_

IF YES, PLEASE LIST THEM HERE:

DO YOU HAVE AN ADVANCED DIRECTIVE (LIVING WILL)? YES \_\_\_\_\_ NO \_\_\_\_\_

**PLEASE READ THE FOLLOWING PARAGRAPHS BEFORE SIGNING**

Payment is expected at the conclusion of each visit. We will file insurance as a courtesy, however it is your responsibility to see that your insurance company pays in a timely fashion. It is your responsibility to pay any deductible, coinsurance or other balance not paid by your insurance company. We file with the credit bureau on delinquent accounts.

IF APPLICABLE, I authorize payment of medical benefits to my physician This assignment will remain in effect until written notice. A copy of this assignment is to be considered valid. I hereby authorize said assignee to release information necessary to secure such payment. I understand that I am responsible for all charges.

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_