



Lake Village Clinic

PATIENT INFORMATION

The Lake Village Clinic will need the following information and it is very important that you bring.

1. All Health Insurance Cards including Medicare, Medicaid and Social Security Card.
2. All medicines you are currently taking.
3. Picture of yourself we can keep for you medical record.

PREFERRED DRUG STORE NAME _____ LOCATION: _____

NAME _____ MAIDEN NAME _____
(LAST) (FIRST) (MI)

SS# _____ SEX _____ DATE OF BIRTH _____

MARITAL STATUS _____ RACE (CIRCLE ONE) CAUCASIAN AFRICAN AMERICAN HISPANIC OTHER: _____

STREET ADDRESS _____ CITY _____ STATE _____ ZIP _____

MAILING ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE _____ CELL OR ALTERNATIVE PHONE _____

PLACE OF EMPLOYMENT _____ OCCUPATION _____

EMPLOYMENT ADDRESS _____ CITY _____ STATE _____ ZIP _____

WORK PHONE _____

EMAIL ADDRESS _____

GUARANTOR INFORMATION

PERSON RESPONSIBLE FOR BILL _____ SS# _____

RELATIONSHIP TO PATIENT _____ SEX _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

EMPLOYER _____ WORK PHONE _____

Lake Village Clinic, 2918 Louis Session St. Lake Village, AR 71653

Phone: (870) 265-5345 Fax: (870) 265-5686

www.LakeVillageClinic.com



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AUTHORIZATION OF MEDICARE, MEDICAID AND INSURANCE BENEFITS

I hereby authorize direct payment of surgical/medical benefits to Lake Village Clinic, for services rendered by him/her in person or under his/her supervision. I understand that I am financially responsible for any balance not covered by my insurance. I certify that the information given by me in applying for payment is correct. I authorize release of all records on request. I request that payment of authorization benefits be made on my behalf.

A photocopy of these assignments shall be valid as the original.

AUTHORIZATION OF RELEASE OF INFORMATION

I hereby authorize Lake Village Clinic to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefit.

EMERGENCY CONTACT INFORMATION

Name of relative not living with you _____ PHONE: _____

I hereby give consent to the Lake Village Clinic to render any treatment they deem necessary for my well-being.

Patient/Guardian _____

Please Print

Patient/Guardian _____

Signature

Date

THE LAKE VILLAGE CLINIC Receipt of Notice of Privacy Practices Written Acknowledgment Form

I, _____ have received a copy of Lake Village Clinic Notice of Privacy Practices.
Patient Name

Patient Signature

Date