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 Cards.
2. All Medicines you are currently taking.
3. Photo ID.

NAME OF PREFERRED DRUG STORE_____LOCATION_____

NAME_____MAIDEN NAME_____
(LAST) (FIRST) (MI)

SS#_____SEX_____DATE OF BIRTH_____

MARITAL STATUS_____RACE (CIRCLE ONE) CAUCASIAN AFRICAN AMERICAN HISPANIC OTHER

MAILING ADDRESS _____CITY _____STATE_____ZIP_____

STREET ADDRESS_____CITY_____STATE_____ZIP_____

HOME PHONE _____CELL OR ALTERNATE #_____

EMPLOYER'S NAME_____

EMPLOYMENT ADDRESS_____CITY_____STATE_____

WORK PHONE_____

EMAIL ADDRESS_____

GUARANTOR INFORMATION

PERSON RESPONSIBLE FOR BILL_____SS#_____

RELATIONS TO THE PATIENT_____SEX_____DOB_____

EMPLOYER_____PHONE NUMBER_____

Lake Village Clinic, 2918 Louis Sessions St., Lake Village, AR. 71653; Phone 870-265-5343, Fax 870-265-5686; website, www.lakevillageclinic.com

AUTHORIZATION OF MEDICARE, MEDICAID AND INSURANCE BENEFITS

I hereby authorize direct payment of all medical benefits to Lake Village Clinic for services rendered by my provider. I understand that I am financially responsible for any balance not covered by my insurance. I certify that I gave the correct information to file for payment. I authorize release of all records upon request.

A photocopy of these assignments shall be as 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.

GENERAL AUTHORIZATIONS

1. I hereby authorize the Lake Village Clinic providers to render any treatment that they consider necessary for my well-being.
2. I hereby authorize the Lake Village Clinic to view my prescription history from external sources.
3. I have received the Notice of Privacy Practices Written Acknowledgment Form

X_____ _____

Patient's signature Date

EMERGENCY CONTACT INFORMATION

Name of relative not living with you_____PHONE_____

Please Print

Lake Village Clinic, 2918 Louis Sessions St., Lake Village, AR 71653
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Website: www.lakevillageclinic.com
Patient Information Form amended 7/19/2022