BAPTIST HEALTH LONOKE FAMILY CLINIC

Name: _____ **DOB:** _____ **SS#:** _____

Race: White
Black
Hispanic
Other: _____

Ethnicity: Hispanic
Non-Hispanic

Primary Language: English
Spanish
Other: _____

Sex: Male
Female

Religion: Christian
Jehovah Witness
Christian Catholic
Other: _____

Employment: Full-time
Part-time
Unemployed
Student

Work location: _____

Work phone: _____

Address: _____ **City:** _____ **State:** ____ **Zip code:** _____

Primary Phone: _____ **Other:** _____ **Home/Cell**

Email: _____ **Primary Care Physician:** _____

Emergency Contact: _____ **Relationship:** _____ **Phone:** _____

Guarantor Information (Person Responsible for Bill)

Name: _____ **Date of Birth:** _____ **Sex: Female/Male**

SS#: _____ **Phone:** _____ **Relationship:** _____

Work Location: _____ **Full-time/ Part-time**

Insurance Information

Primary Insurance Carrier: _____ **Member ID:** _____

Subscriber: _____ **Subscriber DOB:** _____

Secondary Insurance Carrier: _____ **Member ID:** _____

Subscriber: _____ **Subscriber DOB:** _____

I give permission to BHFC LONOKE to speak with the following individuals regarding my medical records (Lab results, insurance, appointments) if I am not available.

Name: _____ **Phone:** _____

Name: _____ **Phone:** _____

I certify that all of the above information is correct for billing purposes and it is my responsibility to notify BHFC LONOKE of any changes to my information.

Patient Signature: _____ **Date:** _____