Jessica Sonnier, M.D. Melissa LeBrun, DNP Mary Dahlen, FNP

REGISTRATION FORM

(Please Print)

Today's date:	PCP:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	☐ Mr. ☐ Mrs.	☐ Miss ☐ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ☐ Yes ☐ No	(Legal or Former name if different)	Social Security no:	Birth date: / /	Age:	Sex: ☐ M ☐ F

Street address:	Cell phone no.: ( )	Home phone no.: ( )
P.O. box:	City:	State:	ZIP Code:
Occupation:	Employer:	Employer phone no.: ( )
Pharmacy:	Other family members seen here:	Referred to clinic by:
Email address:		

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Is this person a patient here? ☐ Yes ☐ No

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance? ☐ Yes ☐ No

Please indicate primary insurance ☐ [Insurance] ☐ [Insurance] ☐ [Insurance] ☐ [Insurance] ☐ [Insurance]

☐ [Insurance] ☐ [Insurance] ☐ [Insurance] ☐ Welfare *(Please provide coupon)* ☐ Other

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-pay: $

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Executive medical clinic of lake charles or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*