Lamoine Valley Clinic Patient Data Form

Thank you for choosing Lamoine Valley Clinic for your health care needs. Please complete the information below before your visit to our office. This will help us to minimize your waiting time.

Personal Information

Name ______________________________ Birthdate ______________
(Last) (First) (Middle) (MM/DD/YYYY)
Address ____
(Street) (City) (State) (Zip)
E-Mail Address ______________________________________
Home Phone ______________________
Social Security Number ____________________ Marital Status ______________
Spouse Name ______________________________ Spouse Work Phone ________________

Insurance Information

Employer Name ______________________________________ Phone ________________
Employer Address ____
(Street) (City) (State) (Zip)
Policy Holders Name ___________________ Policy Holders Date of Birth ________________
Primary Insurance ___________________ Policy Number ________ Group Number ________
Secondary Insurance _________________ Policy Number ________ Group Number ________

Medical Information

Have you ever been told you have…
Diabetes Y / N
High Blood Pressure Y / N
High Cholesterol Y / N
Heart Problems Y / N
Cancer Y / N
Asthma Y / N
Seizures Y / N
Tuberculosis Y / N
Thyroid problems Y / N
Liver Problems Y / N
Kidney Problems Y / N

Have you ever had surgery?
Tonsillectomy Y / N
Gallbladder Y / N
Appendix Y / N
Colon Y / N
Hernia Y / N
Hysterectomy Y / N
Were your ovaries removed? Y / N

Please list your allergies to medications ____
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Current Medications
________________________ ________________________ ________________________
________________________ ________________________ ________________________
________________________ ________________________ ________________________

I hereby authorize payment of benefits, due to me, to be made directly to Lamoine Valley Clinic, S.C. I understand that I am and remain financially responsible for these charges. I authorize the Lamoine Valley Clinic, S.C. to release any information acquired in the course of examination or treatment and allow a photocopy of my signature to be used for this purpose.

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Signature of patient or legal guardian