LAKE AREA PSYCHIATRY, LLC * 333 Dr. Michael DeBakey Dr., Ste. 220, Lake Charles, La. 70601

Please fill out this form completely. For children, include parent's name(s). Also list all phone numbers where you can be reached.

We must have an emergency number for all patients.

Patient Name First Middle Last			Today's Date
Social Security # of Patient	DOB	Age	SEX: MALE FEMALE
The following questions are optional and are used for statistical and research purposes. If you choose not to answer, please check "Declined"	Race: Declined:___	Ethnicity: Declined____	Preferred Language: Declined_____
Mailing Address: City State Zip			
Home Phone# _____ Cell#_____ Alternate Phone No#_____			
Ok to leave message at home? Yes/No	Ok to leave message on cell? Yes/No	Ok to leave message on alternate number? Yes/No	
Patient Employer:	Work#_____ Ok to contact you at work? Yes/No	Occupation	
Marital Status: Married Divorced Single Widowed Remarried	Spouse, Parent or Guardian's Name		
Spouse, Parent or Guardian's Employer	Spouse, parent or Guardian's SS#		
Primary Physician	Phone#	Known allergies:	
Responsible Party/Guarantor			
Guarantor's Address:			
Guarantor's Phone #	Guarantor's Relationship to Patient		
Primary Insurance Company	Policy Holder	Policy Holder DOB	
Policy#	Group#	Insurance Phone No#	
Secondary Insurance Co.	Policy Holder	Policy Holder DOB	
Policy#	Group#	Insurance Phone No#	

Please present insurance card so we may photocopy for our records.

I, the undersigned do hereby irrevocably assign and transfer to _____all rights and benefits whether statutory, common law, contractual or implied, including but not limited to right to sue or recover penalties LSR 22:657. Photo static copy or this assignment of health care benefits shall be as valid and effective as if it were the original. I certify the above information is correct to the best of my knowledge. I also understand that I am financially responsible for all charges whether or not covered by my insurance.

_____ _____ _____ _____

Signature of PATIENT or Authorized Person Date Signature of INSURED or Authorized Person Date

Persons to contact in case of emergency:	Relationship:	Phone#
Persons to contact in case of emergency:	Relationship:	Phone#

Please list the names of people that you authorize our staff to communicate with regarding your appointments and medications:

_____ _____

_____ _____

I certify that I am giving my permission to communicate with the names listed above

_____ Date Signed:_____

SIGNATURE