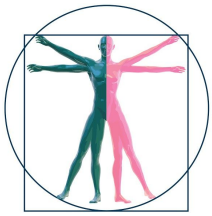

LYONS CARE ASSOCIATES

"for the hope that lives in you"

Patients Name:_____ DOB:__/__/____/_____
Last Name First Name MI

☐ Male ☐ Female SSN:_____ ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widow

Physicial Address:_____

City:_____ State:_____ Zip:_____

Mailing Address:_____
If different from physical address

City:_____ State:_____ Zip:_____

Phone Numbers: Home:_____ Cell:_____ Work:_____

Email:_____ *Sign up for Patient Portal? ☐ Yes ☐ No

*The patient portal allows you to access your medical records, review lab reports, receive email reminders of appointments, request appointments and update demographics on your account. This is great way to communicate with our office.

Emergency Contact:_____ Relationship:_____

Phone Numbers: Home:_____ Cell:_____

Primary Insurance:_____ Subscriber #:_____

Subscriber is not patient:_____ DOB:_____/_____/_____

Secondary Insurance:_____ Subscriber #:_____

Subscriber is not patient:_____ DOB:_____/_____/_____

Primary Care Provider:_____ Referring Provider:_____

Primary Language:_____ Race:_____ Are you Hispanic/Latino: ☐ Yes ☐ No

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I authorize the medical staff of Lyons Care Associates to administer such treatment as may be responsible or necessary in connection with the condition(s) for which I have sought medical care. Authorization is granted to release to my insurance carrier such information as may be necessary for the completion of my medical claims. This authorization shall remain in effect unless specifically rescinded or canceled in writing by the patient.
Please review the HIPPA privacy information attached and initial here:_____

Patient or Authorized Signature:_____ Date:_____

Print Name:_____ Relationship:_____