Lana. D. Louie M.D., F.A.C.S

DIPLOMATE AMERICAN BOARD OF SURGERY
DISEASES OF THE BREAST

PLEASE PRINT **Today's Date:**_____

Patient's Name:_____ I prefer to be called:_____
Last First MI

Name of Person Legally Responsible (if Under Age 18):_____

Date of Birth_____Age_____Social Security:_____

Drivers License #:_____ Marital Status: Single ☐ Married ☐ Other ☐

Home Address:_____
Street Apt # City State Zip

Home Phone #(____)_____Cell Phone: (____)_____Pager:_____

Full-time Student? YES NO E-Mail: _____

Employed By:_____Occupation:_____

Business Address:_____Phone #(____)_____
Street City Zip

Name of Parent/Spouse:_____Occupation:_____
(circle)
Parent/Spouse Employed By:_____Business Phone #(____)_____
(circle)
In Case of Emergency Please Contact:_____
(Name of Nearest Friend or Relative)

Phone #(____)_____Relationship:_____

Referred to This Office By:_____

Name of your Internist:_____ Phone# (____)_____

Allergies to Medications:_____

INSURANCE INFORMATION

_____

(1) Insurance Co. Name Cardholder Name ID#

_____

(2) Insurance Co. Name Cardholder Name ID#

I understand that my insurance will be billed as a courtesy. _____(initials)

I understand that my insurance co-payment portion is due on the date of service. _____(initials)

I understand that should my insurance carrier not pay in a timely manner, I will billed directly for all services rendered. Timely is considered – 60 days from date of service. _____ (initials)

I understand that if I am here for a checkup <u>without a specific problem or diagnosis</u> the insurance company may not pay for my visit today. I am also aware that Dr.Louie is NOT contracted with All HMO/IPA type insurance plans. _____ (initials)

_____ _____

Signature of Responsible Party Date