LEON W. LEWIS, M.D., P.C.

Date: _____ Dr.: _____ Chart #: _____

WELCOME

Thank you for selecting our healthcare team! To help us meet your healthcare needs, please fill out this form completely.

❑ New Patient ❑ Established Patient ❑ Consultation

How did you hear about us? ❑ Friend/Family ❑ Yellow Pages ❑ TV/Advertisement

❑ Referred by Dr. _____ From City _____ State _____

Your Primary Care Physician is: _____ City/State: _____

Patient's Name: First _____ MI _____ Last _____

Patient's Address: _____ City _____ State _____ Zip _____

DOB: _____ SS# _____ ❑ Married ❑ Single ❑ Male ❑ Female

Home # ( ) _____ Mobile # ( ) _____ Work # ( ) _____

Email address: _____

Race: _____ Ethnicity: ❑ Non Hispanic or ❑ Hispanic Language: _____

Employer Name: _____ City: _____

Emergency contact (not living with you):

Name: _____ Relationship to Patient: _____

Work Phone _____ Home Phone _____ Mobile _____

Please list your Allergies: _____

Responsible Party IF DIFFERENT FROM PATIENT

Name:_____ Relationship to Patient: _____

DOB: _____ SS# _____ ❑ Male ❑ Female

Work Phone _____ Home Phone _____ Mobile _____

Employer Name: _____ City: _____

Primary Insurance (Please provide insurance card for us to copy) *Co-Pay Amount $ _____*

Primary Insurance: _____

Name of Insured (as it appears on the card): _____ SS# _____

Subscriber Name: _____ Relationship to Patient: _____

Date of Birth: _____ Policy # _____ Group # _____

Employer Name: _____ City: _____

Secondary Insurance (Please provide insurance card for us to copy) *Co-Pay Amount $ _____*

Primary Insurance: _____

Name of Insured (as it appears on the card): _____ SS# _____

Subscriber Name: _____ Relationship to Patient: _____

Date of Birth: _____ Policy # _____ Group # _____

Employer Name: _____ City: _____

Does your Insurance Require: Referral for Office Visits or Consultation? Primary Y / N Secondary Y / N (Circle Y or N)

Precertification for Outpatient Procedures? Primary Y / N Secondary Y / N (Circle Y or N)

What Hospital does your insurance require you to use? Huntsville Hospitals / Crestwood / Any (Circle One)

Pharmacy to use: _____ :Location / Phone #: _____

Authorization to Release Information and Assignment of Benefits

I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original.

I hereby authorize Leon W. Lewis, M.D., P.C. to apply benefits on my behalf for the covered services rendered by the office, or by the office's order. I request that payment from my insurance company be made directly to Leon W. Lewis, M.D., P.C. or to the party who accepts assignemnt. I certify that the information I have reported with regard to my insurance coverage is correct. In the event of outside collections, I agree to pay all collections costs, including a reasonable attorney fee.

Signature: _____ Date: _____