LUIS LUGO M.D. INTERNAL MEDICINE PORTAL

PATIENT INFORMATION

Previous Doctor:____________________ Phone #_____________________ FAX # _________________________

NAME:____ BIRTH DATE______________________________

SOCIAL SECURITY#_____________________________ MARITAL STATUS: S____ M____ W____ D____

Primary #_____________________________Other #____________________________ Religion_______________

Street Address____

City_____________________________________ State_________________________ Zip_____________________

Email Address____

*Note By providing your email you give consent to our office to contact you electronically. The office of Luis H. Lugo, M.D., is not responsible for any PHI lost in transmission once it leaves our server.

EMPLOYER/SCHOOL____ TITLE___________________________

PHONE #__________________________

STREET ADDRESS____ CITY______________________________

STATE__________________________ ZIP CODE _________________________________

RACE: Hispanic_____ Black_____ White_____ Other_____ ETHNICITY___________________________

PRIMARY LANGUAGE SPOKEN______________________________ REFERRED BY____________________________

Pharmacy Name____________________________________ Pharmacy Phone #______________________________

Xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx

EMERGENCY CONTACT INFORMATION

NAME____ PHONE #____

RELATIONSHIP____________________________________

ADDRESS____ CITY_________________________ STATE________ ZIP_________

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

INSURANCE COMPANY____

ADDRESS_________________________________CITY/STATE/ZIP____

PHONE#________________________________ ID#________________________________ GRP#__________________

INSURED'S NAME OR #_______________________________ INSURED'S SOCIAL SECURITY #__________________________

RELATIONSHIP TO INSURED: SELF_____ HUSBAND_____ WIFE_____ CHILD______ OTHER______

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GUARANTEE OF PAYMENT

I fully understand that I am directly responsible for payments in this office for all medical services rendered to me. I also understand that all bills are payable and become due at the time services are rendered unless other arrangements have been made. I agree to pay all collection costs including reasonable attorney's fees and costs in the event it becomes necessary to file suit to effect payment. I authorize payments to be made directly to the doctor.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize the physicians in this office to release any information acquired in the course of my examination or treatment to my insurance company for the purpose of processing any insurance claim.

ASSIGNMENT OF INSURANCE BENEFITS

If Insurance claims are filed by this office on my behalf, I hereby authorize direct payment of any payment of any benefits to the physicians in this office for medical or surgical treatment received by me. In these circumstances, I understand that I am financially responsible for any charges not covered by insurance. I permit a copy of this authorization to be used in place of the original.

SIGNATURE_____ DATE_____