LARCHMONT
FAMILY MEDICINE
COMPREHENSIVE CARE FOR THE WHOLE FAMILY

Today's' Date: _____

Patient Information

Last Name:	First Name:	Preferred Name:
Mailing Address:		Apt#:
City/State/ZIP:		Date of Birth:

↓ Please check the box next to your preferred phone number. ↓

Home Phone: ☐	Work Phone: ☐	Cell Phone: ☐
Email for Patient Portal:		Can we leave a message about your medical care & test results? YES ☐ NO ☐
Marital Status:	Social Security #:	Are you a Veteran of the US military: YES ☐ NO ☐

Language Needs (if English is not primary): **Indicate your language preference**
☐ Patient requires translation ☐ Spanish ☐ French ☐ Portuguese Other:

Emergency Contact Name:	**Emergency Contact Phone Number:**	**Relationship:**

↓ FOR MINORS ONLY (Under the age of 18) ↓

Mother's Name:	Mother's Phone: ( )	Father's Name:	Father's Phone: ( )

Additional Information

Preferred Pharmacy Name & Location:

Education Level: ☐ Elementary ☐ High School ☐ Vocational ☐ Under Grad ☐ Graduate

Employment Status: ☐ Employed ☐ Full-time Student ☐ Part-time Student ☐ Retired ☐ Self-Employed ☐ Unemployed

Employer:	Job Title:	Number of Employees at this job: 1-10 ☐ 10-99 ☐ 100+ ☐

Race:
☐ White ☐ Native Hawaiian/Pacific Islander ☐ Black/African American
☐ Other ☐ American Indian/Alaska Native ☐ Decline

Ethnicity (please select one):
☐ Hispanic or Latino ☐ Decline
☐ Not Hispanic or Latino

Housing Status:
☐ Single Family Household ☐ Multi-generational Household ☐ Homeless ☐ Shelter ☐ Skilled Nursing Facility ☐ Other: _____

Gender Identity:
☐ Male ☐ Female ☐ Transgender Female to Male ☐ Transgender Male to Female ☐ Non-binary ☐ Other

Primary Insurance

Please provide a current copy of the insurance listed below.

Insurance Plan Name:	Policy ID:	Group ID:
Name of Subscriber:	Relationship to Patient:	DOB Subscriber:
Subscriber's Address:		Apt#:
City/State/ZIP:	Subscriber's Phone (indicate type):	Subscriber's Social Security:

Secondary Insurance

Please provide a current copy of the insurance listed below.

Insurance Plan Name:	Policy ID:	Group ID:
Name of Subscriber:	Relationship to Patient:	DOB Subscriber:
Subscriber's Address:		Apt#:
City/State/ZIP:	Subscriber's Phone (indicate type):	Subscriber's Social Security:

Responsible Party

Statements will be addressed to the Responsible Party – DO NOT FILL THIS OUT IF SAME AS PATIENT

Responsible Party Last Name:	First Name:	Gender:
Date of Birth:	Social Security Number:	Relationship to Patient:
Address:		Apt#:
City/State/ZIP:	Phone (indicate type):	

Social, Health & Cultural Questionnaire

Larchmont Family Medicine practices cultural humility and provides a safe and confidential environment for all patients.

Are there any personal problems or concerns at home, work, or school you would like to discuss today? ☐ YES ☐ NO

Are there any financial issues that directly impact your ability to manage your health? ☐ YES ☐ NO

Are there any transportation issues that directly impact your access to your healthcare providers? ☐ YES ☐ NO

How often do you get the social and emotional support you need? ☐ Always ☐ Usually ☐ Sometimes ☐ Rarely ☐ Never

Do you feel safe in your own home? ☐ Always ☐ Usually ☐ Sometimes ☐ Rarely ☐ Never

Comments (Please comment on any answers marked "yes" above – your provider will discuss these with you during your appointment as well.):

List other providers and their specialty you see on a regular basis (ie. dermatologist, neurologist, psychiatrist)

How did you hear about us?
☐ Internet ☐ Insurance Company ☐ Facebook ☐ Referral from friend/family member ☐ Referral from another office

Other: _____ Name of person who referred you: _____

Attestation & Certification

I certify that the above information is true and correct to the best of my ability. Further I confirm the following:

I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also accept responsibility for the cost of any services which are not covered under the terms of my insurance policy, but which are requested by me or considered to be necessary by my doctor. I am fully responsible for providing accurate and up-to-date information for my insurance for myself or dependents at each and every appointment. Any lapse in coverage or incorrect information will default to my responsibility and will be paid promptly.

I authorize Larchmont Family Medicine or my insurance company to release any information required to process my claims.

Missed appointments are subject to a service charge of $50.00 that will incur billing fees should the balance not be paid promptly.

I understand that payment at the time of service is expected and that a $15.00 billing fee will be processed for any unpaid copayments or bills at the time of service.

I have received a copy or have read a copy of your current Notice of Privacy Practices.

I authorize my doctor at Larchmont Family Medicine to provide medical/surgical treatment for the above-named patient and to release any information pertinent to this care to or from other health care providers.

Name of person completing this form (Print) _____

Todays' Date: _____ Signature _____

Relationship to patient: ☐ Self ☐ Parent ☐ Legal guardian ☐ Other: _____