The Center for Longevity and Wellness

Patient Registration

East Jefferson General Hospital
LCMC Health

Patient Information					
Last Name	First Name	MI	Maiden Name	Gender	Age
Date of Birth	Marital Status	Social Security Number	E-Mail (Home)		
Home Phone ( )	Work Phone ( )	Mobile Phone ( )	E-Mail (Work)		
Address	Zip Code	City	State		
Physician	How or by whom were you referred to this practice?				

Emergency Contact Information				
Last Name	First Name	Home Phone ( )	Work Phone ( )	
Address	City	State	Relationship	

Employment				
Company	Occupation	Home Phone ( )	Work Phone ( )	
Address	City	State		

Primary Insurance Carrier				
Primary Carrier	Name of Insured	Date of Birth	Employer	
SS # of Insured	Group #	Member #		
Co-Payment Amount	Deductible Amount			

Secondary Insurance Carrier				
Primary Carrier	Name of Insured	Date of Birth	Employer	
SS # of Insured	Group #	Member #		

All information I have given is true and complete. This signature will also be used as a "Signature on File" for insurance purposes including any medical information necessary to process the claim. I hereby assign my insurance benefits to be paid directly to The Center for Longevity and Wellness to the extent that they accept assignment. I have read The Center for Longevity and Wellness's Financial Policy and agree that I am ultimately responsible for all non-covered services.

Signature _____ Date _____