Patient Information

Thank you for choosing our office! In order to serve you properly, we need the following information. Please PRINT. All information will be confidential.

Date ______________________

Name Last ______________________ First ______________________ M.I. __________

Phone Home ______________________ Cell ______________________

Email ______________________ **Birth date** __________

Address Street ______________________ Apt __________

City ______________________ State ______________________ Zip __________

Check Appropriate Box ☐ Minor ☐ Single ☐ Divorce ☐ Widowed ☐ Separate ☐ Married

Patient's or Parent's Employer

Work Phone ______________________ Business Address ______________________

City ______________________ State ______________________ Zip __________

Spouse or Parent's Name ______________________

Employer ______________________ Work Phone ______________________

If Patient is a student, name of school/college ______________________

City ______________________ State ______________________

Whom may we thank for referring you? ______________________

Emergency Contact Name ______________________ Phone __________

Responsible Party

Name of person responsible for this account ______________________ Relationship to patient __________

Address ______________________

Home Phone ______________________ Work Phone ______________________

Is this person currently a patient in our office? ☐ Yes ☐ No

Insurance Information

(A copy of your insurance card will be taken at your first visit)

Insurance Company ______________________

Name of Insured ______________________ Member Number ______________________

Relationship to Patient ______________________ Birthday ______________________

I authorize the release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the doctor.

X ____

Signature of patient (or parent if minor)

DR. STEPHANIE LACEY

1795 S. Washington #106 • Naperville, Il 60565 • (630) 961-2848 • drstephanielacey.com