Patient Name	SSN	Date of Birth	Age	Gender ☐ Female ☐ Male
Mailing/Street Address		City, State, Zip Code		
Race ☐ Ameri can Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Greek ☐ Hispanic ☐ Indian ☐ Multi-Racial ☐ Native Hawaiian or other Pacific Islander ☐ White				Ethnicity ☐ Hispanic ☐ Non-Hispanic
Preferred Language ☐ English ☐ Spanish ☐ Other: _____		Marital Status ☐ Divorced ☐ Married ☐ Single ☐ Separated ☐ Widowed		
1st Contact Number	2nd Contact Number	Email Address		
Spouse/Parent's Name	Home Phone Number ( )	Street Address	City, State, Zip Code	

IMPORTANT! PLEASE READ CAREFULLY.
INSURANCE AUTHORIZATION AND ASSIGNMENT OF BENEFITS AND/OR MEDICAL RELEASE.

I hereby authorize Shreveport Internal Medicine, L.L.C to furnish any information or to obtain any information from any insurance carrier, physician, attorney, employer, hospital, other health care provider, or any affiliated entity concerning my medical history, illness and treatments. I hereby assign Shreveport Internal Medicine, L.L.C. all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance.

Date: _____ Signature: _____

INSURANCE COVERAGE		
Insurance #1 – Name of Company:		
Policy Holder Name:	Policy Holder DOB:	Policy Holder SSN:
Insurance #2 – Name of Company:		
Policy Holder Name:	Policy Holder DOB:	Policy Holder SSN: