THE LAPIDUS CLINIC

Personalized Medicine for Healthy Longevity

The Lapidus Clinic Membership Application

Patient Information

Name: Last:		Current Patient: Yes No
First:	MI:	Referring Provider:
Previous Name:		D.O.B.: Age:
Address Line 1:		Sex: M / F
Address Line 2:		Marital Status: □ S □M □ D □W
City:		SS#:
State:	Zip:	Employer Name:
Home Phone:	Cell #:	Status:
Work Phone:	Ext:	Student Status:
Pharmacy:		**Street:** **City:**

Billing Information (if different than above): Circle One: *Guarantor / Spouse / Parent*

Name: Last:	First:	MI:
Relationship:	SS#:	Sex: M / F
Mailing Address:		Zip:
Employer:	Occupation:	
Employer Address:	Employer Phone#:	

Payment Information	***Card number***	***Expiration***	***CVV code***

Insurance Information (Insurance Cards must be provided with Drivers License)

Subscriber's Name:

Subscriber SS#: (if different than above**)** _____/_____/_______ **Relationship to Patient***: □Self □Spouse □Child □Parent*

Primary Insurance Name:		**Secondary Insurance Name:**	

In Case of Emergency Information

Name of a local friend or relative:			**Relationship:**
Emergency Contact #'s	**Home:**	**Work:**	**Cell:**

The above information is true to the best of my knowledge. I understand that I am financially responsible for my balance. I also authorize Dr. Lapidus and/or insurance companies to release any information.

My Spouse and/or _________________ may have access to any of my records/information at Dr. Lapidus:(Circle one) **Yes No N/A**

Patient Signature: ***Date:***