# Locklear Family Practice, PLLC

**Name** _____
Last First Middle

**Address** _____

_____
City State Zip

**Social Security#** _____ **SEX** M F **Date of Birth:** _____

**Home Phone#** _____ **Work Phone#** _____

**Cell Phone#** _____ **Email address** _____

**Primary Insurance** _____

Claim Mailing Address _____

Subscriber Name _____ Patient relationship _____

Employer _____ Phone _____

Employer Address _____

Subscriber Social Security# _____ DOB _____

Insurance ID# _____ Plan/Group# _____

**Seconday Insurance** _____

Claim Mailing Address _____

Subscriber Name _____ Patient relationship _____

Employer _____ Phone _____

Subscriber Social Security# _____ DOB _____

Insurance ID# _____ Plan/Group# _____

**Pharmacy** _____

**Emergency Contact** _____ **Phone Number** _____

It is the patient's responibility to pay deductibles, co-insurance/co-pays on the day of service, and any outstanding balance not paid for by insurance. Self-pay patients must pay for services in full on the day they are rendered. I understand that I am financially responsible for all charges incurred whether paid or not by an insurance carrier. I hereby authorize as the said assignee to release all information necessary to secure payment. This assignment applies to all charges outstanding. My authorized signature will remain in effect for all current and future charges until revoked in writing. A photocopy of this assignment is to be considerd as valid as the original.

**Signature** _____ Date _____

**Print Name** _____

**Parent** (if under age 18) _____ Date _____

**Print Name** _____