

**LAFAYETTE REGIONAL HEALTH CENTER  
REGISTRATION FORM**

LEXINGTON MEDICAL CLINIC HIGGINSVILLE MEDICAL CLINIC  
ODESSA MEDICAL GROUP

**Patient's Information:**

Date: \_\_\_\_\_

Legal Name: First \_\_\_\_\_ M.I. \_\_\_\_ Last \_\_\_\_\_

Sex: M or F Patient's SS# \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_

Patient's Home Phone (\_\_\_\_) \_\_\_\_\_ Cell/Other Phone(\_\_\_\_) \_\_\_\_\_

Marital Status: S M D W Are you employed? Y or N Full-time or Part-time

Employer \_\_\_\_\_

Employer Phone (\_\_\_\_) \_\_\_\_\_

Race: (circle one) AfricanAmerican Hispanic AmericanIndian Asian White Decline

Ethnicity: (circle one) Hispanic/Latino Not Hispanic/Latino Decline

Language: (circle one) English Spanish Other \_\_\_\_\_

E-mail address: \_\_\_\_\_

**Emergency Contact** \_\_\_\_\_ Relation to patient: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

**Responsible Party: (Please send statement to)**

Relationship to Patient: Self Spouse Parent Other \_\_\_\_\_

Name: First \_\_\_\_\_ M.I. \_\_\_\_ Last \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_

SS# \_\_\_\_\_ Date of Birth \_\_\_\_\_ Home Phone (\_\_\_\_) \_\_\_\_\_

Cell/Other Phone (\_\_\_\_) \_\_\_\_\_ Occupation \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_

**Primary Insurance Information:**

Name of Insurance Company \_\_\_\_\_ Employer \_\_\_\_\_

Certificate/ID No. \_\_\_\_\_ Group/Policy No. \_\_\_\_\_

Cardholder's Name \_\_\_\_\_ SS# \_\_\_\_\_ Date of Birth \_\_\_\_\_

**Secondary Insurance Information:**

Name of Insurance Company \_\_\_\_\_ Employer \_\_\_\_\_

Certificate/ID No. \_\_\_\_\_ Group/Policy No. \_\_\_\_\_

Cardholder's Name \_\_\_\_\_ SS# \_\_\_\_\_ Date of Birth \_\_\_\_\_

**PLEASE COMPLETE REVERSE SIDE**

LAFAYETTE REGIONAL HEALTH CENTER RURAL HEALTH CLINICS (LRHC RHC)

Patient Consent Form

*(Please Read and Sign)*

I, the undersigned, hereby consent to the following Treatment:

- Administration and performance of all treatments
- Administration of any needed anesthetics
- Performance of such procedures as may be deemed necessary or advisable in the treatment of this patient
- Use of prescribed medication
- Performance of diagnostic procedures/test and cultures
- Performance of other medically accepted laboratory tests that may be considered medically necessary or advisable based on the judgment of the attending physician or their assigned designees

I fully understand that this is given in advance of any specific diagnosis or treatment.

I intend this consent to be continuing on nature even after a specific diagnosis has been made and treatment recommended. The consent will remain in full force until revoked in writing.

I understand that **LRHC RHC** may include consent at satellite offices under common ownership.

I, the undersigned, acknowledge that **LRHC RHC** will use and disclose my information for the purposes of treatment, payment, and healthcare operations as described in the Notice of Privacy Practices.

A photocopy of this consent shall be considered as valid as the original.

**MEDICARE PATIENTS:** I authorize to release medical information about me to the Social Security Administration or its intermediaries for my Medicare claims. I assign the benefits payable for services to the **LRHC RHC**.

I consent to photographs and/or images of me being recorded for security purposes. I understand that the facility retains the ownership rights to the images. I will be allowed to request access to or copies of the images when technologically feasible unless otherwise prohibited by law. I understand that these images will be securely stored and protected. **Patient Initial** \_\_\_\_\_

I acknowledge that I have been given the LRHC RHC Notice of Privacy Practices. I understand that if I have questions or complaints that I should contact the Privacy Official. **Patient Initial:** \_\_\_\_\_

Advance Directive: Yes \_\_\_ No \_\_\_ (if yes, patient must provide copy for file)

Advance Directive Form: Accepted \_\_\_ Declined \_\_\_

**Primary pharmacy:** \_\_\_\_\_

I authorize **LRHC RHC** to release medical and psychiatric information to:

\_\_\_\_\_  
Print Name –Relation to patient

\_\_\_\_\_  
Print Name –Relation to patient

\_\_\_\_\_  
Print Name –Relation to patient

\_\_\_\_\_  
Print Name –Relation to patient

***I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.***

\_\_\_\_\_  
Patient or Legal Guardian/Representative’s Signature

\_\_\_\_\_  
Date