Claude Luvis, M.D. PA

WELCOME TO OUR PRACTICE

Patient Registration Form

(Please Print)

Today's date:	PCP: Dr. Claude Luvis

PATIENT INFORMATION

Patient's Last Name:	First:	Middle:	☐ Mr. ☐ Mrs.	☐ Miss ☐ Ms.	Marital Status (circle one) Single / Mar / Div / Sep / Wid

Driver's License #:	Email Address:	Mobile Phone # ( )	Birth Date: / /	Age:	Sex: ☐M ☐F

Street Address:	Social Security #:	Home Phone # ( )

P.O. Box:	City:	State:	Zip Code:

Occupation:	Employer:	Work Phone # ( )

Preferred Language: ☐English ☐Other	Do you smoke: ☐Yes, Packs/day: ☐No

Race: ☐White ☐Black ☐Hispanic ☐Asian ☐Other _____

Do you have drug allergies (resulting in shortness of breath, whole body skin rash, or hives)? ☐Yes (Please list which medications) ☐No

1)
2)
3)
4)
5)

INSURANCE INFORMATION

(Please give your Insurance Card and Drivers License to the receptionist.)

Start Date of Insurance:_____ End Date of Insurance:_____

Plan Name: Type of Plan: ☐HMO ☐PPO ☐POS ☐Private ☐Other

Please indicate primary insurance ☐Medicare ☐Medicaid ☐BCBS of NC ☐Humana ☐Cigna ☐Wellpath ☐United Health ☐Tricare ☐No Insurance ☐Other _____

Subscriber's Name:	Subscriber's S.S. #:	Birth Date: / /	Group #:	Policy #:	Co-payment: $

Patient's relationship to subscriber: ☐Self ☐Spouse ☐Child ☐Other

Name of secondary insurance (if applicable):	Subscriber's Name:	Group #:	Policy #:

Patient's relationship to subscriber: ☐Self ☐Spouse ☐Child ☐Other

Please Continue To Next Side

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home Phone #	Work Phone #
		( )	( )

VACCINATION INFORMATION

Flu Vaccine: ☐ Yes ☐ No	Pneumovaccine: ☐ Yes ☐ No	Diptheria/Tetanus/Pertuss(DTP): ☐ Yes ☐ No
Date:	Date:	Date:

FINANCIAL ARRANGEMENTS

Payments for today's services (for copay, coinsurance, deductible)?

☐ Cash ☐ Check ☐ Credit Card ☐ Debit Card

ADDITIONAL INFORMATION

I understand and agree that, (regardless of my insurance status) I am ultimately responsible for the balance on my account for any professional services rendered. I have read the information on this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify Dr. Claude Luvis' office of any changes in my health status or the above information.

I hereby instruct and direct all insurance companies who I have health insurance coverage with, to pay by check and mail to:

Claude Luvis, M.D. PA
2682 Court Dr. Ste. B
Gastonia, NC 28054

Patient/Guardian signature *Date:*

Witness *Date:*