

LAWRENCE INTERNAL MEDICINE, P. A.  
1440 Wakarusa Drive, Suite 300 Lawrence, KS 66049  
785-842-7200

**PATIENT INFORMATION**

Please print clearly.

\_\_\_\_\_/\_\_\_\_\_  
First Name Last Name

**Changes in federal government guidelines require us to ask you the following questions:**

What is your gender?  Male  Female  Other

What is your race? \_\_\_\_\_ What is your preferred language? \_\_\_\_\_

What is your ethnicity?  Hispanic/Latino  Not Hispanic/Latino

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date of Birth Social Security Number Marital Status

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Street Address City State Zip Code

(\_\_\_\_\_)\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Home Phone Number Work Phone Number Cell Phone Number

\_\_\_\_\_  
(e-mail address)

Where can we leave phone messages?  Home  Work  Cell

Employment Status: \_\_\_\_ Full Time \_\_\_\_ Part Time \_\_\_\_ Retired \_\_\_\_ Not Employed

Billing Method: \_\_\_\_ Bill to Insurance \_\_\_\_ Private Pay

**Responsible Party: (name of person who carries your insurance or person responsible for your bill)**

**Complete only if you are not the responsible party.**

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
First Name Last Name Relationship to patient DOB

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Street Address City State Zip Code

(\_\_\_\_\_)\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Home Phone Number Work Phone Number Cell Phone Number

\_\_\_\_\_  
Patient Signature Date