LAGNIAPPE
MEDICAL CENTER

MEMBER INFORMATION

Members Last name First	Middle	Marital status

Is this your legal name?	If not, what is your legal name?	Email address	Date of Birth:	Age:	Sex:
○ Yes ○ No					○ M ○ F

Member Address_____

City_____,State_____, Zip code_____

Social Security number.:	Home phone no.: Mobile phone no.	Social Security number
Employer:	Employer Address:	Employer phone no.:

Preferred Pharmacy_____ Address_____

Phone number _____ Fax_____

How did you hear about us? Family Friend Close to home/work Yellow pages Flyer/mailer other

MEMBER/ OR CORPORATE BILLING INFORMATION

Credit/Debit card monthly auto-payment required for membership fees.

"I consent to having medical information sent to my email address (we cannot guarantee the security of messages delivered by email)."

I hereby authorize Lagniappe Medical Clinic to deduct the payment amount monthly on the day indicated above from My debit/credit card account.

Responsible Billing Party? Member ○ Yes ○ No Company ○ Yes ○ No	Billing Address (if different than Member): ○ Yes ○ No Address: City State: Zip code	Member Card Billing Phone no.: _____ Billing Email Address: _____	First Name on Card: _____ Last Name on Card: _____:

Billing Card Number:	Card Expiration Date:	CVC Code	When would you like your membership to start?
_____	_____	_____	_____

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.:	Work phone no.:

The above information is true to the best of my knowledge. I understand that I am financially responsible for any balances beyond membership plan at the cash pay rate.

_____ _____

Membership signature Date