Bluebonnet Family Clinic, LLC.
Mary K. Thomas, M. D.
9241 Bluebonnet Blvd., Ste. B
Baton Rouge, LA 70810
Phone:225-757-6031 Fax: 225-757-6035

**PLEASE PRINT INFORMATION**

## PATIENT INFORMATION

**Name:**________________________________ **DOB:**________________

Gender: **Male or Female** Marital Status: **single married widow other**
Spouse Name:______________________

**Social Security #:**_______________________________________
**Address:**_______________________________________
**City:**__________________________**State:**_______________**Zip:**_____________
**Home # :**________________**Work #:**__________________**Cell #:**______________
**Email:**______See Attached Email Consent Form__________________
**Employer:**_______________________________________
**Pharmacy and Location:**__________________________________
*****************************************************************************
**Guarantor(Person responsible for bill):**_____________________________________
**Social Security #:**_______________________**Home Phone:**____________________
**Address:**____________________________________________________________
**City:**__________________________**State:**_______________**Zip:**_____________
**Employer:**__________________**Work #**______________**Relationship:**____________
*****************************************************************************
**Insurance Company Name:**___________________________________________
**Insurance Policy Holder Name:**_______________________________________
(If the insurance is through your job you are the insured. If the insurance is through your spouse, parents, or legal guardian job they are the insured. Please put their social and date of birth below.)
**Social Security Number:**__________________**Date of Birth:**_________
**Relationship:**______________________**Phone #:**____________________
*****************************************************************************
**Emergency Contact**
**Name:** ______________________________ **Relationship:**____________________
**Contact number:**_______________________________
*****************************************************************************
**I authorize my medical information to be released to** ___________________________.
**Relationship:**__________________________**Phone #**_________________
**Signature:**____________________________**Date:**____________________
**How did you hear about us?** ____________________________________