# LAKE STREET FAMILY PHYSICIANS

PATIENT REGISTRATION FORM (Please Print)

DATE:_____

## PATIENT INFORMATION

☐ M ☐ F

LAST NAME | FIRST NAME | DATE OF BIRTH | GENDER

☐SINGLE☐MAR☐PART☐DIV☐WID | ☐Am Ind ☐Asian ☐Black/Afr Am ☐Hisp ☐Pac Isl ☐White/Cau☐Other:_____

SOCIAL SECURITY # | MARITAL STATUS | RACE AND ETHNICITY

HOME ADDRESS | CITY | STATE | ZIP CODE

HOME PHONE | WORK PHONE | CELL PHONE

☐HOME ☐WORK ☐CELL ☐EMAIL

EMAIL ADDRESS | PREFERRED METHOD OF CONTACT

## PATIENT'S RESPONSIBLE PARTY INFORMATION

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other:_____

LAST NAME | FIRST NAME | DATE OF BIRTH | SOCIAL SECURITY #

EMPLOYER | EMPLOYER ADDRESS | OCCUPATION

HOME ADDRESS | CITY | STATE | ZIP CODE

HOME PHONE | WORK PHONE | CELL PHONE

☐ HOME☐WORK☐ CELL☐ EMAIL

EMAIL ADDRESS | PREFERRED METHOD OF CONTACT

## PHARMACY INFORMATION

NAME OF PHARMACY | ADDRESS | CITY | STATE | ZIP

PHARMACY PHONE NUMBER | PHARMACY FAX NUMBER

## EMERGENCY CONTACT INFORMATION

NAME | RELATIONSHIP | ADDRESS | CITY | STATE | ZIP

HOME PHONE | WORK PHONE | CELL PHONE