Lake Street
FAMILY PHYSICIANS

PATIENT REGISTRATION FORM (Please Print)

DATE:_____

PATIENT INFORMATION

M F

LAST NAME | FIRST NAME | DATE OF BIRTH | GENDER

SINGLEMARPARTDIVWID | Am Ind Asian Black/Afr Am Hisp Pac Isl White/CauOther:_____

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

INSURANCE INFORMATION

Primary Insurance Plan: _____ GROUP NO: _____ INSURED ID:_____

NAME OF SUBSCRIBER: _____ DATE OF BIRTH: _____RELATIONSHIP TO PATIENT: _____

Secondary Insurance Plan: _____ GROUP NO: _____ INSURED ID: _____

NAME OF SUBSCRIBER: _____ DATE OF BIRTH: _____RELATIONSHIP TO PATIENT: _____

PHARMACY INFORMATION

NAME OF PHARMACY | ADDRESS | CITY | STATE | ZIP

PHARMACY PHONE NUMBER | PHARMACY FAX NUMBER

EMERGENCY CONTACT INFORMATION

NAME | RELATIONSHIP | CELL PHONE | HOME PHONE