

LAKWOOD PRIMARY CARE – PATIENT REGISTRATION FORM

PATIENT NAME		DATE	
ADDRESS		CITY	ZIP
HOME PHONE	WORK PHONE	CELL PHONE	
DATE OF BIRTH	SOCIAL SECURITY #	DRIVER'S LICENSE #	
MARITAL STATUS <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widow	EMPLOYMENT STATUS <input type="checkbox"/> Full Time Emp <input type="checkbox"/> Part Time Emp <input type="checkbox"/> Student/Unemployed <input type="checkbox"/> Retired	AGE	SEX <input type="checkbox"/> Male <input type="checkbox"/> Female
EMERGENCY CONTACT NAME / PHONE #		EMERGENCY CONTACT NAME / PHONE #	

Primary Insurance Company: _____
 Member ID #: _____
 Subscriber Name: _____
 Birthdate: _____ SS#: _____
 Subscriber Relation to Patient: _____
 Employer Name: _____
 Effective Date: _____

2011
New Information Needed:
 Email Address: _____
 Ethnicity: _____
 Race: _____

Secondary Insurance Company: _____
 Member ID #: _____
 Subscriber Name: _____
 Birthdate: _____ SS#: _____
 Subscriber Relation to Patient: _____
 Employer Name: _____
 Effective Date: _____

Primary Language: _____
 Do you have an Advanced Directive?
 YES NO
 If not, may we send you information?
 YES NO

Authorization to Communicate Patient's Medical Information

Please list any family members or others who may be involved in coordinating your care or payment for care. Also, Indicate what kinds of information may be shared with each individual.

Name of Person Authorized to receive information	Relationship to Patient	Type of Information			
		ALL	Medical	Appt	Billing

Validation Code Word: _____ (please give this to any individual who may be involved in coordinating your care or payment for care. They will be asked to give this code to our staff before we release information over the phone.)

Authorization for Release of Information and Assignment of Benefits

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, private insurance, and any other health plan benefits to **ProHealth Partners Inc., dba Lakewood Primary Care**. Furthermore, I authorize the release of medical information necessary to process my insurance claim. I understand that if I receive any payments due to this office, it is my responsibility/obligation to remit payment. **I also understand that I am responsible for the cost of any and all medical services rendered to me.** This assignment will remain in effect until revoked in writing. A photocopy of this assignment is to be considered as valid as the original.

Signed: _____ Printed Name: _____ Date: _____