Date _____

LAST NAME_____FIRST NAME_____MIDDLE INITIALS_____

SEX_____DATE OF BIRTH_____AGE_____SOCIAL SECURITY NO_____

ADDRESS_____CITY_____STATE_____ZIP_____

HOME PHONE_____ WORK PHONE _____ ext_____

CELL PHONE _____ E-MAIL _____

MARITAL STATUS: ☐Married ☐Single ☐Widowed ☐ Divorced

RACE_____ ETHNICITY _____LANGUAGE_____

American Indian	Hispanic	African American	Hispanic	English	Polish
Asian	White	American Indian	Hispanic/Latino	German	Spanish
Black/African American	More than One	European	Unreported	Italian	Other

PHARMACY NAME_____STREET/CITY_____PHONE_____

EMPLOYER_____ADDRESS_____CITY_____STATE_____ZIP_____

SPOUSE'S NAME_____CELL PHONE_____WORK PHONE_____

NEAREST FRIEND/RELATIVE NOT RESIDING WITH YOU_____PHONE_____

RESPONSIBLE PARTY – GUARANTOR

PLEASE COMPLETE THE SECTION BELOW IF SOMEONE OTHER THAN THE PATIENT IS RESPONSIBLE FOR THE BILL

NAME_____ADDRESS_____City_____STATE_____ZIP_____

HOME PHONE_____RELATIONSHIP TO PATIENT_____DATE OF BIRTH_____

OCCUPATION_____EMPLOYER_____ADRESS_____

CITY_____STATE_____ZIP_____

DRIVERS LICENSE #_____ SOCIAL SECURITY #_____

MEDICAL INSURANCE INFORMATION

Primary Insurance

INSURANCE CO_____NAME OF SUBSCRIBER_____DATE OF BIRTH_____

AUTHORIZATION

I hereby authorize any representative from Lakeview Family Doctors to discuss any part of my medical history with

_____ at _____ _____

Name Home Phone/Cell Number Relationship to patient

_____

Signature

AUTHORIZATION

BENEFITS TO LAKEVIEW FAMILY DOCTORS: I hereby authorize patients directly to Lakeview Family Doctors for the Surgical and/or Medical benefits. I also understand that I am responsible for any portion of my bill not covered by my Insurance Company including Medicare.

Signature (Patient/Guarantor) _____ Date_____

RELEASE OF MEDICAL INFORMATION: I herby authorize release of information for Insurance Claim purposes. Photocopies of the insurance cards are as valid as the original. I have read and understand all of the above and herby state that the information is correct to the best of my knowledge. My signature indicates that I approve and grant the request of the authorization

Signature (Patient/Guarantor) _____ Date_____