PATIENT REGISTRATION INFORMATION

Patient Name: _____ Date of Birth: _____ Sex: ☐ Male ☐ Female

Address: _____ City: _____ Zip: _____

Home #: _____ Work #: _____ Cell #: _____

Social Security #: _____ Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Race/Ethnicity: _____ Preferred Language: English or _____

Local Pharmacy: _____ Phone: _____ Fax: _____

For Patient Portal Access, email: _____ Appt Reminders: ☐ Voice Message ☐ Text

How you heard about us: ☐ Drive by ☐ Internet search ☐ Through your insurance provider ☐ Former patient

☐ Referred by a patient, name (optional) _____ ☐ Other: _____

PRIMARY INSURANCE INFORMATION

☐ Check if patient is subscriber and then skip to step 2. Otherwise, complete steps 1 & 2.
If patient has Medicaid, patient's parent is the subscriber. Please complete steps 1 & 2

1. Name of subscriber: _____ Date of Birth: _____ Sex: ☐ Male ☐ Female

Address of subscriber (if different from above): _____

Phone # of subscriber: _____ Social Security #: _____

Relationship to Patient: _____

2. Name of Primary Insurance Company: _____ Effective Date: _____

Employer of Subscriber: _____ Work #: _____

Policy/Subscriber ID #: _____ Group #: _____ Co-Pay: $ _____

SECONDARY INSURANCE INFORMATION (IF APPLICABLE)

☐ Check if patient is subscriber and then skip to step 2. Otherwise, complete steps 1 & 2.
If patient has Medicaid, patient's parent is the subscriber. Please complete steps 1 & 2

1. Name of subscriber: _____ Date of Birth: _____ Sex: ☐ Male ☐ Female

Address of subscriber (if different from above): _____

Phone # of subscriber: _____ Social Security #: _____

Relationship to Patient: _____

2. Name of Secondary Insurance Company: _____ Effective Date: _____

Employer of Subscriber: _____ Work #: _____

Policy/Subscriber ID #: _____ Group #: _____ Co-Pay: $ _____

EMERGENCY CONTACT- Please provide a phone number other than the ones listed above.

Name: _____ Phone: _____ Relationship: _____

I hereby authorize my insurance benefits to be paid directly to Lake Country Family Medicine. I understand that I am responsible for all charges whether or not they are covered by my insurance. In the event of default, I agree to pay all associated costs including collections and attorney's fee. I hereby authorize Dr. Yung Chen, D.O. or Dr. Jill Gramer, D.O. to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be valid as the original.

Patient/Parent Signature: _____ Date: _____