

# LAKESHORE CLINIC

## PATIENT REGISTRATION

*Please answer all questions completely or write "N/A" on non-applicable items.*

<b>Patient Information</b>			
Date	Last Name	First Name	Jr / Sr/ MD M.I.
Mailing Address		Apt/Space #	City State Zip Code
/ /	Sex: M or F	Social Security #	Race (optional) Employer
( )	home work cell other	( )	home work cell other
Primary Phone	<i>Please circle one</i>	Secondary Phone	<i>Please circle one</i> E-mail Address
<b>Parent Information</b>			
<b><u>If applicable and patient is under 18 years of age</u></b>			
Last Name	First Name	M.I.	
Mailing Address		Apt/Space #	City State Zip Code
/ /	Sex: M or F	Social Security #	Employer Occupation / Position
( )	home work cell other	( )	home work cell other
Primary Phone	<i>Please circle one</i>	Secondary Phone	<i>Please circle one</i> E-mail Address
<b>Primary Insurance Company:</b>		<b>Secondary Insurance Company:</b>	
Group #	Policy / Subscriber #	Group #	Policy / Subscriber #
Policyholder Name	Date of Birth	Policyholder Name	Date of Birth
Policyholder Address	Social Security #	Policyholder Address	Social Security #
Relationship to Patient	Policy Effective Date	Relationship to Patient	Policy Effective Date
<b>Person to contact in case of emergency</b>			
Emergency Contact Name	Relationship to Patient	Cell Phone	Daytime Phone