LAKE HEALTH PHYSICIAN GROUP
REGISTRATION

NAME:_____

DOB:_____

Date:

Primary Care Physician:

PATIENT

First Name | Middle Initial | Last Name

SSN

Sex ☐ male ☐ female

Race _____

Ethnicity ☐ Non Hispanic ☐ Hispanic

Language _____

☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Date of Birth | Employer | Employer Telephone

Patient Mailing Address

Street Address | City | State | Zip

Primary Telephone Number | Alternate Telephone Number

RESPONSIBLE PARTY (Other Than Self)

First Name | Middle Initial | Last Name

SSN | Relationship to Patient | Sex ☐ male ☐ female

Date of Birth | Employer | ☐ Full-time ☐ Part-time | Employer Telephone

Responsible Party Mailing Address (if different from patient)

Street Address | City | State | Zip

Primary Telephone Number | Alternate Telephone Number

EMERGENCY CONTACT

Name | Relationship to Patient

Primary Telephone Number | Alternate Telephone Number

For Office Use Only:

☐ Entered

Initials _____ Date _____

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