LAKEPOINT FAMILY PHYSICIANS

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PATIENT REGISTRATION FORM

PATIENT INFORMATION

Last Name:		First Name:		MI:			
Mailing Address:							
Preferred Phone:		Is this a home		cell		or work phone?	
Date Of Birth:		Sex:		Male		Female	
Marital Status:		Single		Married		Divorced	Widowed
Emergency Contact & Relationship to pt:				Phone:			
Employer Name:							
Employer Address:				Phone:			

INSURANCE AND PAYMENT INFORMATION

Person Responsible for Bill (**Only if different than patient**) Name:							
Date Of Birth:		SS #:		Phone:			
Address:							
Employer Name:							

Primary Medical Insurance	**Secondary Medical Insurance**
Company	Company
Policy Holder:	Policy Holder:
Policy Holder's DOB:	Policy Holder's DOB:
Policy Holder's SS#:	Policy Holder's SS#:
Relationship to Patient:	Relationship to Patient:
Employer Name:	Employer Name:

ADDITIONAL INFO

E-Mail Address:							
Race: Please select one		African American		Asian		Hispanic	
	American Indian / Native Alaskan		Pacific Islander		White		Prefer not to disclose
Ethnicity: Please select one		Hispanic		Non-Hispanic		Prefer not to disclose	
Preferred Language:							
Preferred Pharmacy Name and Location:							

PLEASE COMPLETE THE SECOND PAGE OF THIS FORM AND SIGN

I have read and agree to Lakepoint Family Physician's (LFP) Patient Financial Policy. I understand that payment is my responsibility regardless of insurance coverage. I understand my signature requests that payment be made to the provider and authorizes LFP to furnish the insured's insurance company(s) all information (including HIV, sexually transmitted diseases, drug/alcohol abuse, mental illness, or psychiatric treatment) which may be requested concerning my treatment that is necessary to process the claim. I also authorize the release of information regarding work related injuries to my employer.

I understand that failure to pay outstanding balances or make suitable arrangements within 45 days of notification of the amount due may result in submission to an outside collection service. If my account is sent to an outside collection service, there will be collection fees and/or interest added to my account balance and the full balance of outstanding debt plus collection fees and interest must be paid in full to receive further services at LFP.

I have received and understand the LFP Notice of Privacy Practices. I authorize the following people to receive my protected health information and discuss my care and/or my billing information on my behalf:

1)	Relationship to Patient	
2)	Relationship to Patient	
3)	Relationship to Patient	
4)	Relationship to Patient	

A photocopy of this document shall be valid as the original.

Patient (Print Name): _____

Signature: _____

Date Signed: _____

Guardian (Print Name): _____

Signature: _____

Date Signed: _____

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Office Use Only

A Good faith effort was made to obtain a written acknowledgement of his/her receipt of the Notice, but such acknowledgement could not be obtain because:

_____ Refused to sign

_____Patient/Representative was unable to sign

_____ The Patient had a medical emergency and an attmept to obtain the acknowledgement will be made later

Signature of Workforce member _____ Date _____