LAKE HEALTH PHYSICIAN GROUP
ADULT REGISTRATION

Patient Label Pharmacy City:

Pharmacy:

Date: | Primary Care Physician:

PATIENT

First Name | Middle Initial | Last Name

SSN | Race _____ | ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Sex ☐ male ☐ female | Ethnicity ☐ Non Hispanic ☐ Hispanic | Language _____

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

Patient Mailing Address

City | State | Zip

Home Telephone | Cell Phone / Pager | Email Address

RESPONSIBLE PARTY ☐ Check if PATIENT is same as Responsible party and go to Emergency Contact

First Name | Middle Initial | Last Name

SSN | Title | Sex ☐ male ☐ female

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

Responsible Party Mailing Address

City | State | Zip

Home Telephone | Work Telephone | Relationship to Patient

NAME OF RELATIVE/FRIEND IN CASE OF EMERGENCY

Name | Relationship To Patient

Home Telephone | Alternate Phone Number

PRIMARY INSURANCE

Insurance Card Holder First Name | Last Name | Date of Birth | Relationship to Patient

Insurance Company Name | Insurance ID Number | Employer Phone Number

SECONDARY INSURANCE

Insurance Card Holder First Name | Last Name | Date of Birth | Relationship to Patient

Insurance Company Name | Insurance ID Number | Employer Phone Number

PLEASE COMPLETE REVERSE SIDE

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LAKE HEALTH PHYSICIAN GROUP
ADULT REGISTRATION

Patient Label

If necessary, how may we contact you?

Home (_____) - _____ - _____ Work (_____) - _____ - _____

Cell (_____) - _____ - _____ Pager (_____) - _____ - _____

May we leave a message? ☐ Yes ☐ No Answering Machine: ☐ Yes ☐ No

REQUEST FOR GENERAL TREATMENT

I request and authorize Lake Health Physician Group, its employees, my physician, and allied health professionals as are necessary to provide care. Further, I authorize my physician to permit the presence of observers in my treatment as deemed necessary.

I, _____, understand and acknowledge that from time to time, medical students, nursing students or students of other healthcare disciplines may be undergoing clinical education in Lake Health Physician Group. I hereby authorize and permit such students of any such health profession to participate in my care insofar as they are properly supervised at all times by a licensed and credentialed healthcare practitioner in that field of expertise. I acknowledge that I have a right to ask questions of any physician or nurse regarding the use of students in my care at any time.

X _____ Date _____

AUTHORIZATION TO RELEASE INFORMATION (Insurance/Medicare Beneficiaries)

I authorize Lake Health Physician Group to release any medical records or medical information necessary to file an insurance claim, to perform quality and utilization assessments, and to release any medical information which may be requested by my insurance carrier or agencies on their behalf. I authorize release of medical information to a quality assurance of peer review committee or organization, and compliance audits.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. In Medicare assigned cases, the physician agrees to accept the charge determination of the Medicare carrier as the full charge. I am responsible only for the deductible, coinsurance, and non covered services.

I HAVE REVIEWED AND CONSENT TO ALL APPLICABLE CLAUSES BY SIGNING BELOW. I UNDERSTAND THE NATURE OF THIS CONSENT AND IT IS REVOCABLE AT ANY TIME.

Signature X _____ Relationship to Patient _____

Witness to above signature: _____ Date: _____ / _____ / _____

Medicare Received: _____ Date: _____ / _____ / _____
Signature

Privacy Notice Received: _____ Date: _____ / _____ / _____
Signature

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