Lenzmeier Family Medicine Registration Form

(Please Print)

PATIENT NAME ____ Soc. Security # __________________________

HOME ADDRESS ____ APT# ____________

CITY ___________________________________ STATE ______________ ZIP _________________________________

DATE OF BIRTH ______________________________ AGE ___________ SEX: MALE FEMALE

HM PHONE ______________________ WK PHONE _______________________ CELL PHONE _______________________

EMERGENCY CONTACT (NAME &PHONE) ____

RELATIONSHIP TO EMERGENCY CONTACT: ____

EMAIL ____

RESP. PARTY NAME ____________________________________ Relationship to Pt: SELF SPOUSE PARENT OTHER

RESP. PARTY Soc. Security # and Date of Birth (if not SELF) ____

PT EMPLOYER NAME/PHONE ____

IS PATIENT: Single Married Other IS PATIENT: Employed Full-Time Student Part-Time Student Other

PRIMARY INSURANCE:	SECONDARY INSURANCE:
Ins. Co. Name __________________________	Ins. Co. Name ______________________________
Policy Holder Name ______________________	Policy Holder Name __________________________
Relationship to Patient ___________________	Relationship to Patient _______________________
ID # ______________________________	ID# _______________________________________
Policy Holder Sex: M F Date of Birth _________	Policy Holder Sex: M F
Date of Birth ________________ ___________________	

Ins. Co. Address ____________________________ Ins. Co. Address ____________________________________

Ins. Telephone ______________________________ Ins. Telephone ______________________________________

Policy Holder Employer _____________________ Policy Holder Employer _____________________________

Group# ____________________________________ Group# ____

I hereby authorize the staff of Lenzmeier Family Medicine to provide such medical services, either regular or emergency, as may be determined by my physician to be in the patient's (me or my dependent, if signing for minor) best interest.

I authorize payment of medical benefits to Lenzmeier Family Medicine. I agree that all charges for medical services rendered that are not directly paid by my insurance will be my responsibility. In the event it becomes necessary for Lenzmeier Family Medicine to forward my account balance to an outside collection agency, I understand I will also be responsible for paying a $30 collection fee. I hereby authorize Lenzmeier Family Medicine to release the necessary information regarding me to my health insurance plan in order to complete and process my insurance claims.

Patient Signature ____ Date ______________

Parent Signature (if Minor) ____ Date ______________