Lake City Medical Group
Patient Registration Form

Patient Information:

Patient Name: (Last)	(First)	(Middle)	(Alias)

Social Security #	Gender (circle one)	Date of Birth	Email address
	Male Female Other		
Cell phone number	**Home phone number**	**Work phone number**	**Mailing address, City, State, Zip**

Marital Status: (Circle One) Married / Single / Divorced / Widowed / Legally Separated / Other

Employment Status (Check one)		Employed		Full Time Student		Part time Student		Retired		Self Employed		Unemployed	Occupation:

Place of Employment		Employer address	
Emergency Contact		Relation to patient		Contact number	

Responsible Party Information:

Name: (Last)	(First)	(Middle)	(Alias)
Social Security #	Date of Birth	Contact Number	
Street Address		City, State, Zip	

Place of Employment		Employer address	
Occupation		Relation to patient	

Primary insurance Information:

Name of insured		Date of birth		Relation to patient	
Place of Employment		Employer address			
Insured's Social Security #		Type of insurance		Member ID#	
Group #		Effective Date		Termination date	
Insurance Company address				Copay Amount	

Secondary insurance Information:

Name of insured		Date of birth		Relation to patient	

Place of Employment		Employer address			
Insured's Social Security #		Type of insurance		Member ID#	
Group #		Effective Date		Termination date	
Insurance Company address				Copay Amount	

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.

Patient or Responsible party's signature	**Date**