# LAKEWOOD
## FAMILY HEALTH

| PATIENT INFORMATION | | | | ❑ New Patient ❑ Established PT |
|---|---|---|---|---|
| Patient's FIRST Name: | MIDDLE: | LAST: | | Social Security #: |
| Birth date: / / | Sex: ❑ M ❑ F | Marital status (circle one) Single / Mar / Div / Sep / Wid | Employment Status (circle one) Employed / Retired / Student / Not-Employed | Employer Name: |
| Your Address: | | City | State: | Zip Code: |
| Race: ❑ Decline ❑ White ❑ American Indian /Alaska Nat. ❑ Asian ❑ Black/African American ❑ Nat.Hawaii/Oth Pac Islander ❑ Other | | Ethnic Group: ❑ Non-Hispanic ❑ Hispanic/Latino ❑ Decline | | Language: ❑ English ❑ Spanish ❑ Other:________ |
| Primary Phone#: ❑ Cell ❑ Work ❑Home ( ) | | Alternate Phone#: ❑ Cell ❑ Work ❑Home ( ) | | Email Address: Appointment reminder by email? ❑ Yes ❑ No |
| Reason for Visit? | | How did you hear about our office? | | |

| RESPONSIBLE PARTY: | | | |
|---|---|---|---|
| Person Financially Responsible [Guarantor] ❑ Self Only→ Skip to insurance section ❑ Other Guarantor→ Complete this section | Guarantor's Full Name: | | Patient's Relationship to Guarantor: ❑ Child ❑ Spouse ❑ Other: |
| Address (if different): | | Birth date: / / | Social Security #: |

| INSURANCE INFORMATION: | | | |
|---|---|---|---|
| **Primary** Insurance Company Name: | | Plan Name: | Type of Plan: ❑ PPO ❑ POS ❑ HMO ❑ Medicaid ❑ Medicare ❑Tricare ❑ Medicare HMO ❑ Multi-Plan |
| Policy#: | | Group #: | Group Name: |
| Is plan thru employer? ❑ No ❑ Yes | Employer address: | | Occupation: |
| **Secondary** Insurance Company Name: | | Plan Name: | Type of Plan: ❑ Medicare Supplemental ❑ Medicaid ❑ Other Employer/Commercial ❑ Spouse's Plan (Pls. complete guarantor section) ❑ Other: |
| Policy#: | | Group #: | Group Name: |
| Is plan thru employer? ❑ No ❑ Yes | Employer Name & Address: | | |

**ACKNOWLEDGEMENT:**

**The above information is true to the best of my knowledge. I consent to the use and disclosure of my protected health information for treatment, payment and healthcare operations as described in this clinic's Notice of Privacy Practices. I authorize my insurance benefits be paid directly to Lakewood Family Health as indicated on the claim.**

**I understand that I am financially responsible for all fees and balances, regardless of insurance coverage.**

Patient/Guardian signature: ______________________ Date ____________

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