Lakeshore Gastroenterology & Liver Disease Institute

PATIENT REGISTRATION FORM

GENERAL INFORMATION

PRIMARY CARE PHYSICIAN (PCP):	PCP PHONE NUMBER:
DOCTOR	( )

PATIENT'S LAST NAME:	FIRST NAME:	MIDDLE INITIAL:	SEX: PLACE AN X ON THE LINE
			__ Male __ Female

MARITAL STATUS: PLACE AN X ON THE LINE	SOCIAL SECURITY NUMBER:	BIRTH DATE:
___ Single ___ Married ___ Divorced ___ Widowed ___ Separated		

STREET ADDRESS:	APT:	CITY:	ZIP CODE:

HOME PHONE NUMBER:	WORK PHONE NUMBER:	CELL PHONE NUMBER:
( )	( )	( )

EMAIL ADDRESS:	

INSURANCE INFORMATION

PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST.

INSURANCE NAME:	SECONDARY INSURANCE:

NAME OF SUBSCRIBER:	RELATIONSHIP TO SUBSCRIBER:	SUBSCRIBER BIRTH DATE:

EMERGENCY CONTACT

NAME OF CONTACT:	RELATIONSHIP TO PATIENT:

HOME PHONE NUMBER:	WORK PHONE NUMBER:	CELL PHONE NUMBER:
( )	( )	( )

RELEASE OF INFORMATION

Due to HIPAA Regulations, we are unable to give information such as biopsy and lab results to anyone not listed on this form. Please list the following people you give consent for your information to be given to:

NAME:		RELATIONSHIP:	
NAME:		RELATIONSHIP:	
NAME:		RELATIONSHIP:	

RELEASE OF CONFIDENTIAL HEALTH

_____ INITIALS

I give the physicians at Lakeshore Gastroenterology my authorization to release my medical records to my primary physician and/or to obtain medical records needed for evaluation.

I, _____ authorize evaluation and treatment.

PRINT / WRITE NAME HERE

I declare that the above information is true and correct.

_____ _____

PATIENT/GUARDIAN SIGNATURE DATE