Lakeland Regional Health®

REGISTRATION FORM

(Please Print)

Today's Date:

PATIENT INFORMATION

Patient's last name: First: Middle:	☐ Mr. ☐ Mrs.	☐ Miss. ☐ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Race:	Birth date: / /	Sex: ☐ Male ☐ Female

Street address:	Social Security Number:	Home phone: ( )

P.O. box:	City:	State:	Zip code:

Email address:	Cell phone: ( )

Primary care provider:

INSURANCE INFORMATION

(Please give your insurance cards and a photo ID to the Receptionist)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone #: ( )

Name of primary insurance:

Subscriber's name:	Subscriber's SSN:	Birth date: / /	Group #:	Policy #:

Patients relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

Name of secondary insurance (if applicable):

Subscriber's name:	Group #:	Policy #:

Patients relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone: ( )	Work phone: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to Lakeland Regional Health. I understand that I am financially responsible for any co-pays, deductibles, co-insurance and balances not covered by my insurance and is payable at the time of service. I also authorize Lakeland Regional Health to release any information to my insurance carrier required to process my claims.

_____ _____

Patient/Guardian Signature Date