LAKE FOREST ACUTE CARE

REGISTRATION FORM

(Please Print)

PATIENT INFORMATION

Patient's last name: First: Middle:	❑ Mr. ❑Mrs.	❑ Miss ❑ Ms.	SS# __ __ __- __ __ - __ __ __ __
Marital status: (circle one) Single / Married / Divorced / Separated / Widow / Child	Sex ❑ Male ❑ Female ❑ Decline		Birth Date _____ /_____ /_____
Street address:	PO BOX		Home phone no.: ( )
City:	State	Zip Code:	Cell phone no: ( )
Occupation:	Employer:		Employer phone no.: ( )

Chose clinic because/Referred to clinic by (please check one box):

❑ Dr. ❑ Insurance Plan ❑ Hospital ❑ Mailer ❑ News Paper

❑ Family ❑ Friend ❑ Internet ❑Sign ❑ Yellow Pages

❑ Other _____

_____

Email address

Race: ❑ American Indian or Native Alaskan ❑ Asian ❑ Black or African American ❑ Native Hawaiian or Other Pacific Islander ❑ White ❑ Decline

Ethnicity: ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ Decline

BILLING & INSURANCE INFORMATION

Please give your Insurance Card to the receptionist or provide the following information:

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Is this person a patient here? ❑ Yes ❑ No

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Primary insurance: Address:

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑Child ❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber: ❑❑ Self ❑❑ Spouse ❑❑ Child ❑❑ Other

IN CASE OF EMERGENCY

Name:	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Lake Forest Acute Care or insurance company to release any information required to process my claims.

_____ _____

Patient/Guardian signature *Date*