



LAKESIDE SURGICAL  
ASSOCIATES, PA

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## *PATIENT REGISTRATION*

### **Address & Identification**

Today's Date: \_\_\_\_\_

Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Gender: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Employer & Address: \_\_\_\_\_

Nearest Relative (not living with you): \_\_\_\_\_

Address: \_\_\_\_\_ Telephone: \_\_\_\_\_

How did you Hear about Us?: \_\_\_\_\_

### **Spouse/Guardian if Patient is a Minor**

Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Social Security #: \_\_\_\_\_

### **Physician Information**

Primary Physician: \_\_\_\_\_

Referring Physician: \_\_\_\_\_

### **Insurance Information** Your card should have the policy number and other pertinent info

Primary Insurance: \_\_\_\_\_

Name of Insured: \_\_\_\_\_ Date of Birth \_\_\_\_\_ Social Security # \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_

Name of Insured: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Workman's Compensation Claim: \_\_\_\_\_

Automobile Accident : \_\_\_\_\_ Date of Accident: \_\_\_\_\_

Policy Number for W/C or Auto Claim: \_\_\_\_\_