Lake Ridge Internal Medicine, PC

REGISTRATION FORM

Last Name: _____ First Name: _____ M.I.: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (_____) _____ Cell Phone: (_____) _____

Sex: □ Male □ Female Birth Date: _____ SS#: _____

Marital Status: □Married □Widowed □Single □Separated □Divorced □Minor □Partnered for _ yrs

Email address: _____

Spouse Name (if any):_____

Emergency Contact (Name/Number): _____

Whom may we thank for referring you? _____

Preferred Pharmacy: _____

EMPLOYER

Patient Employer/ School : _____

Employer Address: _____

Occupation: _____ Employer Phone Number: (_____) _____

HEALTH INSURANCE

Name of Health Insurance Company: _____

Account Holder (If not self) : _____

Account Holder Relationship to Patient, If not self: □ Spouse □ Parent

ASSIGNMENT & RELEASE

I certify that I, and/or my dependant(s), have Insurance coverage with the company noted above, and I assign directly to Lake Ridge Internal Medicine, PC / Dr Bassam Farah all Insurance benefits for service rendered. I understand that I am financially responsible for all charges not covered by Insurance. I authorize the use of my signature on all insurance submissions.

Lake Rdige Internal Medicine, PC may disclose my health care information to my insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits.

_____ _____

Signature of Patient or Guardian Date