

# LAKESIDE ENT & ALLERGY

## Patient Registration

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ M / F  
*Last First Middle*

Phone (*Home*) \_\_\_\_\_ (*Cell*) \_\_\_\_\_ (*Other*) \_\_\_\_\_

SS#: \_\_\_\_\_ Address \_\_\_\_\_  
*Street City Zip*

Patient **e-mail** address: \_\_\_\_\_

Patient's Employer Name: \_\_\_\_\_

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

Responsible Party Name: \_\_\_\_\_

## Primary Insurance Information

Name of Insurance Carrier: \_\_\_\_\_ Ins. ID# \_\_\_\_\_

Address of Insurance Carrier: \_\_\_\_\_  
*Street City Zip*

Phone Number of Insurance Carrier: \_\_\_\_\_

Subscriber Name (*If different than patient*) \_\_\_\_\_ M / F

Relationship to patient: \_\_\_\_\_ DOB: \_\_\_\_\_

## Secondary Insurance Information

Name of Insurance Carrier: \_\_\_\_\_ Ins. ID# \_\_\_\_\_

Address of Insurance Carrier: \_\_\_\_\_  
*Street City Zip*

Phone Number of Insurance Carrier: \_\_\_\_\_

Subscriber Name (*If different than patient*) \_\_\_\_\_ M / F

Relationship to patient: \_\_\_\_\_ DOB: \_\_\_\_\_

## Contact Information

Name (*Someone not living with you*): \_\_\_\_\_

Contact Address: \_\_\_\_\_

Contact Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

Accident Related: YES \_\_\_ NO \_\_\_ Date of Accident: \_\_\_\_\_

Type of Accident: Motor vehicle \_\_\_ Work \_\_\_ School \_\_\_ Liability \_\_\_