LAKEWOOD FAMILY MEDICINE
PATIENT INFORMATION SHEET FOR MINORS

Name ____
First Middle Last

Address ____
Ave/Street/Drive/Blvd City State Zip

DOB:_______________ ☐ Male ☐ Female

Parents: ☐ Married ☐ Divorced ☐ Separated ☐ Other

*If Separated or Divorced; Who Does Child Reside With: ☐ Father ☐ Mother

FATHER

Name ___________________________

Address (if different than patient)

____

____

Home (Landline) Phone #_______________

Work Phone # _______________________

Cell Phone #_________________________

SS #: ______________________

Birth Date: _____/_______/_____

MOTHER

Name ___________________________

Address (if different than patient)

____

____

Home (Landline) Phone #________________

Work Phone # _______________________

Cell Phone #_________________________

SS #: ______________________

Birth Date: ______/______/_____

Which phone number should be listed as primary contact for the patient?

☐ Landline ☐ Father Work ☐ Mother Work ☐ Father Cell ☐ Mother Cell

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INSURANCE INFORMATION

Primary Insurance: ____
Name of Insurance Company Employer Group #

____
Policy Holder Name (Relationship to Patient) Policy Holder Date of Birth Policy Holder's Social Security #

Second Insurance: ____
Name of Insurance Company Employer Group #

____
Policy Holder Name (Relationship to Patient) Policy Holder Date of Birth Policy Holder's Social Security #

Primary Care physician at Lakewood Family Medicine is Dr. ___________________________

Lakewood Family Medicine
Acknowledgement of Receipt of Privacy Notice

Name Patient ______________________ Date of Birth ______________

I acknowledge that Lakewood Family Medicine's "Notice of Privacy Practices" has been offered and/or provided to me.

I understand I have a right to review Lakewood Family Medicine's Notice of Privacy Practices prior to signing this document. Lakewood Family Medicine's Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Lakewood Family Medicine. The Notice of Privacy Practices for Lakewood Family Medicine is also provided on request at the main administration desk of this practice. This Notice of Privacy Practices also describes my rights and Lakewood Family Medicine's duties with respect to my protected health information.

Lakewood Family Medicine reserves the right to change the privacy practices, in observance with Federal laws that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by accessing Lakewood Family Medicine's website, calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Signature of Patient or Personal Representative ______________________ Date ______________

Name Personal Representative ______________________ Relationship ______________

Witness ______________________

Lakewood Family Medicine

Signature Authorization & Assignment of Benefits

Patient's Name: ___________________________

Patient's Date of Birth: _____________________

Release of Information

I authorize the release of any medical information necessary; 1) to process claims, 2) to be referred to a specialist for medical care, 3) to obtain services for lab, x-ray, and other diagnostic services. I also authorize that this information may be faxed, if necessary.

Assignment of Benefits

I authorize that insurance payments of medical benefits be paid directly to Lakewood Family Medicine for the services rendered.

Responsibility of Payment

I authorize and accept responsibility for payment of any balance; 1) remaining after payment of insurance benefits, 2) not covered by insurance for whatever reason, 3) due to finance charges, 4) deemed not covered by workman's compensation, 5) deemed not covered by auto insurance

Date: ____________

Signature of Patient, Parent or Legal Representative: ___________________________

Relationship to pt: _________________________________

Date: ____________

Signature of Spouse: ____________________________

Date: ____________

Signature of Parent; of patient 18 years and older: _________________________

***Patient that is 18 years and older MUST also sign this form in the patient field above.