

**LAKWOOD FAMILY MEDICINE  
PATIENT INFORMATION SHEET FOR MINORS**

Name \_\_\_\_\_  
*First Middle Last*

Address \_\_\_\_\_  
*Ave/Street/Drive/Blvd City State Zip*

Social Security # \_\_\_\_ - \_\_\_\_ - \_\_\_\_ DOB: \_\_\_\_\_  Male  Female

Primary Phone # (\_\_\_\_) \_\_\_\_\_  Cell  Home  Work  Other \_\_\_\_\_

Secondary Phone # (\_\_\_\_) \_\_\_\_\_  Cell  Home  Work  Other \_\_\_\_\_

E-mail Address \_\_\_\_\_

\*E-mail Address MUST be a parent's.

Emergency Contact (outside of home) \_\_\_\_\_  
*Name Phone # Relationship*

Parents:  Married  Divorced  Separated  Other  
\*If Separated; Who Does Child Reside With:  Father  Mother

**FATHER**

**MOTHER**

Name \_\_\_\_\_

Name \_\_\_\_\_

Address (if different than patient) \_\_\_\_\_  
\_\_\_\_\_

Address (if different than patient) \_\_\_\_\_  
\_\_\_\_\_

Phone # \_\_\_\_\_  Cell  
 Home  Work

Phone # \_\_\_\_\_  Cell  
 Home  Work

SS #: \_\_\_\_\_

SS #: \_\_\_\_\_

Birth Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Birth Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

A financial statement will be sent to the parent/guardian where the minor resides. Would you like a statement sent to both father and mother?  Yes  No

\*If Yes, MUST supply address.

**PLEASE NOTE: PAYMENT IS THE RESPONSIBILITY OF BOTH PARENTS.**

**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. \_\_\_\_\_