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

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 patient: _____

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.