Lakeside Primary Care P C

PATIENT INFORMATION

Name:	Date of Birth:
Address One:	Social Security #:
Address Two:	Sex:
City:	Language:
State: Zip:	Employer:
Home Phone#:	Emergency Contact:
Work Phone#:	Emergency Phone#:
Cell Phone#:	Emergency Relationship:

GUARANTOR INFORMATION

Name:	Date of Birth:
Address One:	Social Security #:
Address Two:	Sex:
City:	Language:
State: Zip:	Employer:
Home Phone#:	Emergency Contact:
Work Phone#:	Emergency Phone#:
Cell Phone#:	Emergency Relationship:

INSURANCE INFORMATION

Primary Insurance:	Secondary Insurance:
Member ID:	Member ID:
Group Number:	Group Number:
Group Name:	Group Name:
Copay:	Copay:
Subscriber Name:	Subscriber Name:

The information I have given on this form is true to the best of my knowledge. I hereby authorize Lakeside Primary Care/ David C. Harrison, MD to release medical information to the insurance company(ies) listed above. Also, by my signature and copies thereof, I authorize payment directly to Lakeside Primary Care/ David C. Harrison, MD for benefits otherwise payable to me. I understand that I am financially responsible for any charges not covered by this authorization and any attorney or collection fees, if applicable. I also understand that I will be financially responsible for fees for missed or “no show” appointments, which are not billable to my insurance.

_____ _____

Signed (patient or parent if minor) Date