Dr. Kimberly A. Lemke, P.C.

PATIENT REGISTRATION FORM- *MINOR*

(Please Print)

Today's Date:	Appt. With:	Whom may we thank for referring you?

PATIENT INFORMATION

Last Name, First Name, Middle Initial			Birth Date:	Sex: ❑ Other ❑ Male ❑ Female
Street Address	City	State	Zip Code	Home Phone No.:

PHONE NO. WE MAY LEAVE A MESSAGE ABOUT PATIENT?

MOTHER'S INFORMATION

Last Name, First Name, Middle Initial			Birth Date:	Home Phone No.:
Street Address	City	State	Zip Code	Cell Phone No.:
Employer's Name, Address and Work Phone				

FATHER'S INFORMATION

Last Name, First Name, Middle Initial			Birth Date:	Home Phone No.:
Street Address	City	State	Zip Code	Cell Phone No.:
Employer's Name, Address, and Work Phone				

PRIMARY INSURANCE INFORMATION

Insured's Last Name, First Name, Middle Initial	Birth Date:	Social Security #
Insurance Company	Phone Number	
Insurance Billing Address:		

Policy No.:	Group no.:	Relationship to Insured ❑ Self ❑ Spouse ❑ Dependent

SECONDARY INSURANCE INFORMATION (IF APPLICABLE)

Insured's Last Name, First Name, Middle Initial	Birth Date:	Social Security #
Insurance Company	Phone Number	
Insurance Billing Address:		

Policy No.:	Group no.:	Relationship to Insured ❑ Self ❑ Spouse ❑ Dependent

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the doctor. I understand that I am financially responsible for any balance. I also authorize Dr. Kimberly A. Lemke, P.C, and those acting on the practice's behalf and the insurance company to release any information required to process my claims. Furthermore, I have reviewed the Notice of Privacy Practices & the Professional Service Agreement provided. I fully understand and accept the terms of this practice.

Signature of Patient (age 12 & older) Date

Guardian Signature Date