

DR. KIMBERLY A. LEMKE, P.C.

PATIENT REGISTRATION SHEET

Today's Date:		Provider:				
PATIENT INFORMATION						
Last Name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid
Street Address:		City:		State:	ZIP Code:	
Home phone no.: ()	Cell/Other contact no.: ()	Social Security no.:		Birth Date: / /	Sex: <input type="checkbox"/> Other <input type="checkbox"/> M <input type="checkbox"/> F	
Employer:		Occupation:		Work phone no.: ()		
Street Address:		City:		State:	ZIP Code:	
Referring Doctor (if required by insurance):						
Notify Primary Care Physician? <input type="checkbox"/> YES <input type="checkbox"/> NO		Name of Primary Care Physician		Contact no.: ()		
IN CASE OF EMERGENCY						
Emergency Contact Name:		Home phone no.: ()		Cell phone no.: ()		
INSURANCE INFORMATION						
Insured's Last Name (if different):		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid
Home phone no.: (if different) ()	Cell/Other contact no.: ()	Social Security no.:		Birth Date: / /	Sex: <input type="checkbox"/> Other <input type="checkbox"/> M <input type="checkbox"/> F	
Insurance Company:		Insurance Billing Address:		Insurance phone no.: ()		
Policy no.:	Group no.:	Relationship to Insured:	<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Dependent	
SECONDARY INSURANCE INFORMATION (IF APPLICABLE)						
Insurance Company:		Insurance Billing Address:		Insurance phone no.: ()		
Policy no.:	Group no.:	Relationship to Insured:	<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Dependent	
<p>The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the therapist. 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 my insurance company to release any information required to process my claims.</p> <p>Furthermore, I have reviewed the Notice of Privacy Practices & the Professional Service Agreement provided. I fully understand and accept the terms of this practice.</p>						
_____ Patient/Guardian signature				_____ Date		

*** PLEASE NOTE: 24 HOUR CANCELLATION POLICY – Please be advised that 24 hours notice is required for cancellations. Otherwise, your account will be charged for the session amount. Thank you for your cooperation.**