

# Lakeshore Family Practice

2308 Homer Clayton Drive Guntersville, AL 35976 Phone 256-582-2581 Fax 256-582-7799

Stephen B Henderson MD Nancy G Seaman CRNP

## PATIENT REGISTRATION

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ M.I. \_\_\_\_\_  
Mailing Address: \_\_\_\_\_ Apt # \_\_\_\_\_  
City/State/Zip: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Preferred Number:  Home  Cell  Work Email Address: \_\_\_\_\_  
DOB: \_\_\_\_\_ SSN: \_\_\_\_\_ Marital Status: \_\_\_\_\_ Gender: \_\_\_\_\_  
Employer: \_\_\_\_\_ Address: \_\_\_\_\_  
Occupation: \_\_\_\_\_ Preferred Language: \_\_\_\_\_  
Race:  White  Hispanic  Black  Asian  American Indian or Alaska Native  Other  Decline  
Ethnicity:  Hispanic or Latino  Not Hispanic or Latino  Decline  
Emergency Contact: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone #: \_\_\_\_\_

**Responsible Party** – If the patient is a minor, the parent or guardian bringing the patient in will be listed as the guarantor

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ SSN: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_ Relation to Patient: \_\_\_\_\_

### PRIMARY MEDICAL INSURANCE

Insurance Name: \_\_\_\_\_  
Contract # \_\_\_\_\_ Group # \_\_\_\_\_ Co-pay \_\_\_\_\_  
Name of Insured \_\_\_\_\_ Relation to Patient: \_\_\_\_\_  
Gender: \_\_\_\_\_ DOB: \_\_\_\_\_ SSN: \_\_\_\_\_

### SECONDARY MEDICAL INSURANCE

Insurance Name: \_\_\_\_\_  
Contract # \_\_\_\_\_ Group # \_\_\_\_\_ Copay \_\_\_\_\_  
Name of Insured \_\_\_\_\_ Relation to Patient \_\_\_\_\_  
Gender: \_\_\_\_\_ DOB: \_\_\_\_\_ SSN: \_\_\_\_\_

I understand that I am fully responsible for all charges incurred during care and treatment, regardless of any insurance benefits I may have. I understand that my insurance company may not reimburse all charges incurred and I am responsible for all charges not satisfied in full by my insurance except where liability is limited by contract or State/Federal law. As the patient and/or Guarantor, I understand that if my account balance remains unpaid for a period of 90 days that Lakeshore Family Practice retains the right to institute whatever method necessary to collect the unpaid balance. I will also be responsible for the cost of collection fees should my account be turned over to a collection agency. I authorize the release of any medical information necessary to facilitate processing my insurance claims. I hereby assign all insurance benefits provided by my insurance company directly to Lakeshore Family Practice. I certify that the information I have reported with regard to the patient's insurance coverage is correct.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Responsible Party Signature (if minor): \_\_\_\_\_ Date \_\_\_\_\_

Printed Name of Responsible Party \_\_\_\_\_ Relation to Patient \_\_\_\_\_

