LAKESIDE OB/GYN, S.C. PATIENT REGISTRATION FORM	
First/Middle/Last NAME	Nickname
Street Address	Date of Birth
City State Zip Code	Home phone ( )
Marital Status Married Single Widowed Separated Divorced Partnered	Cell phone ( )
Former/Maiden	Social Security #
PATIENT EMPLOYER INFORMATION	
Employer Name	Work phone ( )
Occupation	May we call you at work? YES NO
EMERGENCY CONTACT	
Name	Relationship
Street Address	Home phone ( )
City State Zip Code	Cell phone ( )

INSURANCE INFORMATION	
PRIMARY	SECONDARY
Insurance Co Name*	Insurance Co Name*
Subscriber ID#	Subscriber ID#
Group/Policy#	Group/Policy#
Send claims to:	Send claims to:
Phone ( )	Phone ( )
Name of policy holder*	Name of policy holder*
Relationship to patient*	Relationship to patient*
Date of Birth of policy holder*	Date of Birth of policy holder*
Employer of policy holder*	Employer of policy holder*
Address of policy holder*	Address of policy holder*

PATIENT HEALTH INFORMATION	
Primary care provider	Pharmacy/Pharmacy phone ( )
Referred by	Allergies

ALL PATIENTS: All labs are sent to WDL (Froedtert) or ACSM (Ascension), if this is not accepted by your insurance, it is your responsibility to inform Lakeside OB/GYN, S.C. prior to the time of your appointment. HMO patients: You are responsible for getting referrals from your primary care physician prior to your appointment and paying any copay on the date of service.
SELF-PAY PATIENTS: Full payment is required on the date of service. To show our appreciation a discount is given.

ACKNOWLEDGEMENT/AUTHORIZATION

My signature below acknowledges the accuracy of the above information. I agree to keep Lakeside OB/GYN, S.C. informed of any changes related to the above information. I understand my medical care could be compromised and result in adverse effects on my health if Lakeside OB/GYN, S.C. is limited by inaccurate information. Lakeside OB/GYN, S.C. will make every attempt to contact patients when needed utilizing all the information available. I understand that I am responsible for any part of the fee that my insurance company does not cover and I agree to pay Lakeside OB/GYN, S.C. any outstanding balance on my account. I request that all insurance payments be sent directly to Lakeside OB/GYN, S.C. and hereby authorize the release of any information acquired in the course of my examinations or treatments to be released to my insurance company. In the event of unanticipated and unforeseen medical treatment needs, including urgent or emergent testing or surgeries, payment arrangements will be made so as not to interfere with quality patient care.

SIGNATURE	DATE
PRINT NAME/RELATIONSHIP TO PATIENT IF NOT SIGNED BY PATIENT	