Cornerstone Health - Lakeview Pediatrics

Patient Registration Information

Patient's Legal Name _____ ☐ Male ☐ Female
FIRST MIDDLE LAST

Date of Birth _____ Address _____
STREET CITY STATE ZIP

Home Phone _____ Emergency Contact _____
OTHER THAN PARENT Name Relationship Phone

This must be an adult who lives with the patient and usually comes to appointments - if possible, the mother. All health & financial communications will be sent to this person.

Adult #1 _____

☐ Parent ☐ Stepparent ☐ Legal Guardian ☐ Other ☐ Male ☐ Female Marital Status

Legal Name _____ ☐ Male ☐ Female
FIRST MIDDLE LAST

Date of Birth _____ SS# _____ Phones _____
(THIS INFORMATION IS REQUIRED FOR US TO BILL YOUR INSURANCE) HOME CELL WORK

Employer _____ Occupation _____

Adult #2 ☐ Parent ☐ Stepparent ☐ Legal Guardian ☐ Other ☐ Male ☐ Female Marital Status

Legal Name _____ ☐ Male ☐ Female
FIRST MIDDLE LAST

Date of Birth _____ SS# _____ Phones _____
(THIS INFORMATION IS REQUIRED FOR US TO BILL YOUR INSURANCE) HOME CELL WORK

Employer _____ Occupation _____

Address (if different than child's) _____
STREET CITY STATE ZIP

Primary Insurance _____
INSURANCE NAME PLAN TYPE POLICY NUMBER GROUP NUMBER

SUBSCRIBER RELATIONSHIP TO PATIENT EMPLOYER (if not listed above) BIRTHDATE (if not listed above) SS# (if not listed above)

Other Insurance _____
INSURANCE NAME PLAN TYPE POLICY NUMBER GROUP NUMBER

SUBSCRIBER RELATIONSHIP TO PATIENT EMPLOYER (if not listed above) BIRTHDATE (if not listed above) SS# (if not listed above)

Patient's siblings (brothers & sisters, half-brothers & sisters, step-brothers & sisters – please specify)

FULL LEGAL NAME	SEX	BIRTH DATE	RELATIONSHIP	FULL LEGAL NAME	SEX	BIRTH DATE	RELATIONSHIP

If we have scheduled an appointment for you in advance, and you are unable to keep it, please give us 24 hours notice. Failure to do so may result in a $25 Missed-Appointment charge.

I hereby assign medical benefits due to me to be paid to Cornerstone Health / Lakeview Pediatrics. I consent to the release of medical information necessary to process any insurance claims and to any other doctor for the continuation of my medical care. I understand that a photocopy of this release is as valid as the original.

Signature: _____ Date: _____