LAKE REGIONAL® HEALTH SYSTEM Pre-Registration Form

Procedure/Test Being Performed_____ Date of Service_____ Ordering Physician_____

Family Physician_____ Maiden/Other Name_____ Mother's First Name_____

Patient Name (Last, First, MI)_____

Address_____ City/State/ZIP_____

Phone_____ Cell _____ Date of Birth_____ Race_____

Religious Preference _____ SSN_____ Marital Status: (circle one) M S D Sep W

Patient's Employer _____

Address_____ City/State/ZIP_____

Work Phone_____ Employment Status: (circle one) Full Time Part Time Retired Disabled Unemployed Student

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Guarantor (if different than above)_____ Guarantor's SSN_____

Relationship to Patient_____ Guarantor's Address_____

Guarantor's Employer_____ Guarantor's Employer Phone _____

Address_____ City/State/ZIP_____

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Primary Insurance _____ Insurance Company Phone_____

Address_____ City/State/ZIP_____

Policy #_____Group #_____Policy Holder's Name_____

Secondary Insurance _____ Insurance Company Phone_____

Address_____ City/State/ZIP_____

Policy #_____Group #_____Policy Holder's Name_____

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Primary Emergency Contact _____ Relationship to Patient_____

Address_____ City/State/ZIP_____

Home Phone _____ Work Phone _____ Cell Phone _____

Secondary Emergency Contact _____ Relationship to Patient_____

Home Phone _____ Work Phone _____ Cell Phone _____

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Are clergy visits permissible if admitted? (circle one) Yes No

Would you like anyone to have access to your medical bills? (circle) Yes No

If yes, who? _____ Relationship to Patient_____

Do you have an advance directive for medical care decisions? (circle) Yes No

Do you have a durable power of attorney? (circle) Yes No

If yes, who? _____ Relationship to Patient_____