LAKESIDE ENDOSCOPY CENTER, LLC

REGISTRATION FORM

Patient Label

Please bring your completed forms, your insurance card(s) and a photo ID with you the day of your procedure.

PATIENT INFORMATION

First Name | **Middle Initial** | **Last / Former Name**

Street Address | **City** | **State** | **ZIP Code**

/ / | ❑ Male ❑ Female | ❑ English ❑ Spanish ❑ Other _____

Birth date | **Social Security No.** | **Gender** | **Primary Language**

Primary Phone | **Secondary Phone** | **Employer**

Single / Mar / Div / Sep / Wid

Marital Status (circle one) | **Spouse Name** | **Spouse Phone**

REFERRING PRACTITIONER INFORMATION

Practitioner who referred for procedure (First & Last Name)

Street Address

City | **State** | **Zip Code**

Add'l Practitioner who will need procedure report (First & Last Name)

Street Address

City | **State** | **Zip Code**

MEDICAL INSURANCE INFORMATION

Primary Insurance Company | **Policy Holder Name** | **Relationship To Policy Holder (circle one)**

Self / Spouse / Parent / Other: _____

Secondary Insurance Company | **Policy Holder Name** | **Relationship To Policy Holder (circle one)**

Self / Spouse / Parent / Other: _____

Tertiary Insurance Company | **Policy Holder Name** | **Relationship To Policy Holder (circle one)**

POLICY HOLDER INFORMATION (IF OTHER THAN SELF)

First Name | **Middle Initial** | **Last Name** | **Employer**

Date of Birth | **Social Security Number** | **Primary Phone**

Street Address | **City** | **State** | **Zip**

CONTACT INFORMATION (RIDE HOME & EMERGENCY)

Ride Contact Name | **Relation of Contact** | **Primary Phone** | **Secondary Phone**

Emergency Contact Name | **Relation of Contact** | **Primary Phone** | **Secondary Phone**