



# PATIENT REGISTRATION

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<b>PATIENT INFORMATION</b>		(PRINT: FIRST NAME, LAST, MIDDLE INITIAL, BELOW)	(MONTH ##) (DATE ##) (YEAR ##)
<b>PATIENT NAME:</b> Mrs. Ms. Mr.			TODAY'S DATE:
DATE OF BIRTH: (MONTH ##) (DATE ##) (YEAR ####)		[PARENT OR GUARDIAN NAME]:	
SEX: M <input type="checkbox"/> F <input type="checkbox"/>	MARITAL STATUS: M <input type="checkbox"/> S <input type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/>	HOME PHONE:	
SOCIAL SECURITY #:		CELL PHONE:	
CONTACT PREFERENCE: HOW CONFIDENTIAL MSGS COMMUNICATED (CELL/HOME PHONE, EMAIL, OTHER..)		EMAIL:	
HOME ADDRESS:		CITY:	STATE: ZIP CODE:
EMPLOYER:		WORK PHONE:	
EMPLOYER ADDRESS:		CITY:	STATE: ZIP CODE:
HAS ANY OTHER IMMEDIATE FAMILY MEMBER BEEN SEEN IN THIS OFFICE? YES: <input type="checkbox"/> NO: <input type="checkbox"/>		IF YES, NAME:	RELATIONSHIP TO PATIENT:
<b>EMERGENCY CONTACT</b>			
NAME:		PHONE:	RELATIONSHIP TO PATIENT:
<b>INSURANCE INFORMATION</b>			EFFECTIVE DATE: (MONTH ##) (DATE ##) (YEAR ##)
<b>PRIMARY INSURANCE:</b>			
PATIENT RELATIONSHIP TO SUBSCRIBER: SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> OTHER <input type="checkbox"/> (DESCRIBE:)		SUBSCRIBER DATE OF BIRTH: (MONTH ##) (DATE ##) (YEAR ##)	
SUBSCRIBER'S NAME:		SUBSCRIBER'S SOC. SECURITY #:	
SUBSCRIBER'S EMPLOYER:		SUBSCRIBER I.D. #:	GROUP #:
<b>SECONDARY INSURANCE</b>			[CLAIM #:]
WORKMAN COMP / AUTO:			
DATE OF ACCIDENT OR INJURY: (MONTH ##) (DATE ##) (YEAR ##)		[PARENT OR GUARDIAN NAME]:	
PATIENT RELATIONSHIP TO SUBSCRIBER: SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> OTHER <input type="checkbox"/> (DESCRIBE:)		SUBSCRIBER DATE OF BIRTH: (MONTH ##) (DATE ##) (YEAR ##)	
SUBSCRIBER'S NAME:		SUBSCRIBER'S SOC. SECURITY #:	
SUBSCRIBER'S EMPLOYER:			
SUBSCRIBER I.D. #:		GROUP #:	
<b>PHARMACY INFORMATION</b>			
PHARMACY:		PHARMACY ADDRESS:	
PHARMACY FAX#:		PHARMACY PHONE:	
<b>FEEDBACK</b>			
HOW DID YOU HEAR ABOUT OUR OFFICE? FRIEND <input type="checkbox"/> WEBSEARCH <input type="checkbox"/> INSURANCE <input type="checkbox"/> OTHER <input type="checkbox"/> (DESCRIBE:)			
<b>INTERNAL USE ONLY:</b> NEW FAMILY <input type="checkbox"/> NEW PATIENT / ESTABLISHED FAMILY <input type="checkbox"/> UPDATED INFO <input type="checkbox"/>			