Lake Huron Medical Center

Primary Care Physician:____________________________________ Phone #____________________

Patient Information

Last Name:__________________________ First Name:__________________________ M.I________

Previous Last Name:____________________________

Date Of Birth:_________________ Sex: M____ F____ T _____ Social Security #_____________________

Address:______________________________ City:______________________ State:_____ Zip:______

Cell Phone #_________________ Home Phone #___________________ Work #____________________

Can We Text Your Number? Yes_____No_____ Phone # to text: ___________________________________

E-Mail Address:____

Race: Caucasian______ African American______ Hispanic______ Other (List) __________________________

Language: English______ Spanish________ Other_______________

Marital Status: Married______ Single_______ Partner_______ Other______________

Pharmacy:____

Insurance Information

Primary Insurance Company:_______________________________________

Name of Insured:______________________ Date Of Birth:_______________ Sex: M_____F______T____

Other Insurance:____

Name of Insured:______________________ Date of Birth:________________ Sex: M_____F_____T_____

Yes____ No_____ May we leave messages, which may include but not limited to, information about prescriptions or test results on you answering machine?

Yes____ No_____ May we leave messages, which may include but are not limited to, information about prescriptions or test results with members of your household? ~

~If Yes Please list the names: _______________________________________

Emergency Contact Person or Nearest Relative

Last Name:____________________________, First Name:________________________

Relationship (If any)______________________, Phone # __________________________

Signature:____ Date:_______________________