LAKES INTERNAL MEDICINE

Lakes Medical Center • 2300 Haggerty Road, Suite 2150 • West Bloomfield, MI 48323

PLEASE PRINT CLEARLY

MEDICATION ALLERGIES: **Today's Date:** _____

_____ **Date of Birth:** _____

_____ **Soc. Sec.#:** _____

NAME: _____

AGE: _____ **SEX:** **M** ☐ **F** ☐

☐ **SINGLE** ☐ **MARRIED** ☐ **WIDOWED** ☐ **DIVORCED**

ADDRESS: _____ **APT#:** _____

CITY: _____ **STATE:** _____ **ZIP:** _____

HOME PHONE: _____ **DAY PHONE:** _____

CELL PHONE: _____ **E-MAIL:** _____

EMPLOYER: _____ **OCCUPATION:** _____

SPOUSE'S NAME: _____ **SPOUSE D.O.B.** _____

SOC. SEC. # (spouse): _____ **WORK PHONE (spouse):** _____

NEAREST RELATIVE OUTSIDE OF THE HOME (for emergency contact):

_____

RELATIONSHIP: _____ **PHONE NUMBER:** _____

REFERRED BY: _____

PREFERRED LOCAL PHARMACY - LOCATION AND PHONE NUMBER:

_____

_____

MAIL ORDER PHARMACY: _____

Please hand all medical insurance cards and driver's license to the receptionist.

I authorize any holder of medical or other information about me to release such information as necessary to process these medical claims. I understand that I am financially responsible to the doctor for charges not covered by this assignment.

SIGNATURE: _____