Mindy E. Lam, DPM 870 Route 146, Clifton Park, NY 12065 (P) 518-371-7133 (F) 518-371-7135

PATIENT REGISTRATION FORM

Patient Name:_____ Date of Birth: _____
Street Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Cell: _____ Work: _____
Email: _____ Preferred form of contact: ◯ Home ◯ Cell ◯ Work ◯ Email
Marital Status: _____ SS#_____

Parent/Guardian

Name: _____ DOB: _____/_____/_____ ◯ Male ◯ Female
Relationship to the patient: ◯ Mother ◯ Father ◯ Stepmother ◯ Stepfather ◯ Other: _____
SS#_____ Marital Status: _____
Home/cell phone: _____ Work phone: _____
Address: ◯ Same as patient. If not please list address here:
Street Address: _____ City: _____ State: _____ Zip: _____

Other Parent/Guardian

Name: _____ DOB: _____/_____/_____ ◯ Male ◯ Female
Relationship to the patient: ◯ Mother ◯ Father ◯ Stepmother ◯ Stepfather ◯ Other: _____
SS#_____ Marital Status: _____
Home/cell phone: _____ Work phone: _____
Address: ◯ Same as patient. If not please list address here:
Street Address: _____ City: _____ State: _____ Zip: _____

Primary Care

Physician Name: _____ Location: _____ Date Last Seen: _____

Insurance

Primary Insurance: _____ Primary Policyholder: _____
Policyholder Date of Birth: _____ Relationship to Policyholder: _____
Policy ID#: _____ Group #: _____

Secondary Insurance

Secondary Insurance: _____ Secondary Policyholder:_____
Policyholder Date of Birth: _____ Relationship to Policyholder: _____
Policy ID#: _____ Group #: _____

Privacy Information Preferences

- May we send mail to the address on file? ◯ Yes ◯ No
- May we call the phone numbers on file? ◯ Yes ◯ No
- May we leave a voicemail on answering machines? ◯ Yes ◯ No
- Persons Authorized to receive medical information and/or messages:

_____

Signature: _____ **Date:** _____