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: _____________ Gender ◯ Male ◯ Female
Street Address: _________________________________ City: ___________________ State: _______ Zip: ________
Home Phone: ______________________ Cell: ________________________ Work: _______________________
Email: _______________________________________ Preferred form of contact: ◯ Home ◯ Cell ◯ Work ◯ Email
Employer: _______________________________ Marital Status: ________ SS#_______________________

Parent/Guardian

Name: ____ DOB: ______/______/______ ◯ Male ◯ Female
Relationship to the patient: ◯ Mother ◯ Father ◯ Stepmother ◯ Stepfather ◯ Other: ________________
SS#_____________________ Marital Status: _________ Email:________________________________
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: _________ Email:________________________________
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:

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Signature: _____________________________________ **Date:** ____________________________