

**LAFAYETTE REGIONAL HEALTH CENTER
REGISTRATION FORM**

LEXINGTON MEDICAL CLINIC HIGGINSVILLE MEDICAL CLINIC WAVERLY CLINIC
ODESSA MEDICAL GROUP CONCORDIA MEDICAL GROUP

Patient's Information:

Legal Name: First _____ M.I. _____ Last _____

Sex: M or F Patient's SS# _____ Date of Birth _____

Address _____ City _____ State _____ Zip _____

Patient's Home Phone (____) _____ Cell/Other Phone _____

Marital Status: S M D W Are you employed? Y or N Full-time or Part-time

Occupation _____ Employer _____

Employer's Address _____ City _____ State _____ Zip _____

Race: ____ African Am. ____ Hispanic ____ Am. Indian ____ Asian ____ White ____ Decline

Ethnicity: ____ Hispanic/Latino ____ Not Hispanic/Latino ____ Decline

Language: ____ English ____ Spanish ____ Other

In case of emergency notify _____ Telephone(____) _____
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Responsible Party/Insured Information (Please send statement to):

Relationship to Patient: Self Spouse Parent Other _____

Name: First _____ M.I. _____ Last _____

Address _____ City _____ State _____ Zip _____

SS# _____ Date of Birth _____ Home Phone(____) _____

Cell/Other Phone(____) _____ Occupation _____

Employer _____ Work Phone(____) _____

Employer's Address _____ City _____ State _____ Zip _____

Primary Insurance Information:

Name of Insurance Company _____ Employer _____

Certificate/ID No. _____ Group/Policy No. _____

Cardholder's Name _____ SS# _____ Date of Birth _____

Secondary Insurance Information:

Name of Insurance Company _____ Employer _____

Certificate/ID No. _____ Group/Policy No. _____

Cardholder's Name _____ SS# _____ Date of Birth _____

PLEASE COMPLETE REVERSE SIDE