The Lung Center and Sleep Clinic
5161 B Drive S, Ste. A
Battle Creek, MI 49015
(269) 969-6099
www.lungcenterandsleepclinic.com

Adult Patient Registration Form

Due to new Federal Government requirements regarding Electronic Medical Records, we are now required to collect certain data. Race, Ethnicity and Preferred Language are three of the new questions we must ask. If you prefer not to give that information, please mark those choices "Refused".

All information must be filled out – if you are uncomfortable answering any of the questions, please mark them "Refused". Our receptionists are required to return the form to you to complete if not filled out. Thank you for your cooperation!

Patient Name: _____ Preferred Name:_____

Social Security Number:_____ Date of Birth:_____

Address:_____

Preferred Contact Phone:_____ Alternate/Cell Phone:_____

Patient Email Address:_____

Emergency Contact:_____ Relationship to Patient _____ Phone:_____

Preferred Language:_____ Race:_____

Ethnicity (circle one): Hispanic/Latino Not Hispanic/Latino Refused

Family Doctor:_____ Referring Doctor:_____

Marital Status (circle one): Married Single Divorced Separated Widowed

Insurance Information

Primary Insurance:_____ Policy ID:_____ Group #:_____

Insurance Subscriber:_____ Relationship to Patient:_____

Subscriber Date of Birth:_____ Subscriber Employer:_____

Secondary Insurance:_____ Policy ID:_____ Group #:_____

Insurance Subscriber:_____ Relationship to Patient:_____

Subscriber Date of Birth:_____ Subscriber Employer:_____

Patient Employment Information

Are you employed (circle): Full-time Part-time Not employed Retired Military Duty Self-employed

Employer:_____ Occupation:_____

Employer Address:_____

Work Phone:_____ May we call you at work? Yes No