FAMILY PHYSICIANS OF KENDALL, L.L.C.
NORMA S. LAKE, M.D.

11160 SW 88TH STREET, SUITES 104, TEL 786-263-0911, FAX 786-263-0761

PATIENT REGISTRATION

Patient's Name _____ Age _____ Sex____

Date of birth _____ SS#_____ Email_____

Address _____ City_____ State_____ Zip_____

Telephone H _____ W_____ C_____

Significant Other_____ Tel:H_____ W_____ C_____

Emergency Contact_____ Relationship_____

Tel W_____ H_____ C_____

Patient's Employer Information

Employer's Name_____ Tele #_____

Employer's Address_____ Patient's Occupation_____

Insured Person (if not patient)

Name of Insured_____ Relationship to Patient_____ Tel #_____

ID #_____ Group #_____ Tel #_____

Secondary Insurance Co_____ Grp#_____ ID#_____

Medicaid # (if applicable) _____ Medicare # (if applicable) _____

Authorization To Release Information And Assignment Of Benefit And Patient's Obligation For Payment

I authorize the release of any medical information necessary to process this claim. I authorize Family Physicians of Kendall (F.P.of K) L.L.C. and/or Dr. Norma Lake to apply for benefits on my behalf for services rendered to me. I request that payment from my insurance company be made directly to F. P. of K L.L.C. and/or Dr. Norma Lake (or to the party who accepts assignment), and I agree that liability for payment rests with me in the event that my insurance company does not reimburse. I certify that all the information that I have provided herein is correct. I authorize the use of a copy of this registration form be used in place of the original. The authorization maybe revoked at anytime in writing.

Signature_____ Date_____

Revised 9/14/10

How did you know about this practice/doctor? Advertisement __ Friend __ Patient __ On line __ Other__