Lakeland Regional Health®

REGISTRATION FORM

(PLEASE PRINT)

Today's Date:	Medical Record #:

PATIENT INFORMATION

Patient's Last Name	First Name	Middle	Date of Birth	Sex ☐ M ☐ F
Home Address:		City		
		State	Zip	
Social Security Number	Race	Preferred name to be called		
Email address		Phone number		

EMERGENCY CONTACT (Friend or Relative)

Name	Date of Birth
Relationship	Phone Number

IF PATIENT IS 18 YEARS OLD OR YOUNGER, FILL OUT THE INFORMATION BELOW:

MOTHER (check one) ☐ Birth ☐ Stepmother ☐ Adoptive ☐ Foster / Legal Guardian? ☐ Yes ☐ No

Mother's Last Name	First Name	SS#
		Date of Birth
Home Address		City
		State Zip
Mother's Employer Name & Address		Home Phone
		Cell Phone
		Work Phone

FATHER (check one) ☐ Birth ☐ Stepfather ☐ Adoptive ☐ Foster / Legal Guardian? ☐ Yes ☐ No

Father's Last Name	First Name	SS#
		Date of Birth
Home Address		City
		State Zip
Father's Employer Name & Address		Home Phone
		Cell Phone
		Work Phone