Lakeside Primary Care
1001 Waterdam Plaza Drive
McMurray, PA 15317
724-969-1001

PATIENT INFORMATION

Social Security #: _____-_____-_____ Birthdate: _____

Last Name: _____ First Name: _____ Middle Initial: _____

If patient is a minor, please list parent or guardians name: _____

Street Address: _____ PO Box#: _____

City: _____ State: _____ Zip: _____

Home Phone #:_____Cell #:_____Work#:_____

Marital Status: Married / Divorced / Widowed / Single / Other

Emergency Contact **(not living in your home)**:

_____

Phone #:_____ Relationship: _____

Pharmacy Used:_____

***HOW ARE YOU RELATED TO THE PERSON WHO CARRIES YOUR INSURANCE?

PLEASE CIRCLE ONE- SELF / HUSBAND / WIFE / CHILD / PARENT / OTHER

INSURANCE INFORMATION

Type of Insurance: _____ ID#:_____ Group#_____

Subscriber / Guarantor Info:

Social Security #: _____-_____-_____ Date of Birth: _____

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

Address: **(if different than above)** _____

City: _____ State: _____ ZIP: _____

Phone: _____