Great Lakes Physician Practice, PC

New Patient Information

Patient Name _____DOB _____

If patient under 18, parent or guardian:

Name:_____ DOB_____

SSN:_____

Address _____ City _____State _____ Zip _____

Home Phone ( ) _____ Cell Phone ( ) _____

Work Phone ( ) _____ E-Mail _____

Pharmacy _____

Referring Doctor _____ Phone ( ) _____

Primary Care Physician _____ Phone ( ) _____

Marital Status: ◯ Single ◯ Married ◯ Divorced ◯ Widowed

Race: ◯ Caucasian (white) ◯ African American ◯ Asian ◯ OTHER _____

Ethnicity: ◯ Hispanic or Latino ◯ Not Hispanic or Latino

Language: ◯ English ◯ Spanish ◯ OTHER _____

PLEASE GIVE ALL CURRENT INSURANCE CARDS TO OFFICE FOR SCANNING.
You are required to present this information at every visit.

PRIMARY INSURANCE ***(please complete information that is different from above)***

Name of Insured _____ ◯ ◯ Sex: M / F DOB _____

Insured's Address _____ City _____ State _____ Zip _____

Name of Insurance Company_____

Insured's Employer_____

Address _____ City _____ State _____ Zip _____

Employer Phone ( ) _____

SECONDARY INSURANCE

Name of Insurance Company_____

Name of Insured _____ ◯ ◯ Sex: M / F DOB _____

Insured's Address _____ City _____ State _____ Zip _____

Insured's Employer _____

Address _____ City _____ State _____ Zip _____

Employer Phone ( ) _____

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