Patient Information

Lakeview Family Medicine
Phone: (801) 434-7600 Fax: (801) 434-7604
Email: reception@lakeviewdoctors.com

Crossroad Family Medicine
Phone: (801) 766-2121 Fax: (801) 768-2612
Email: reception@lakeviewdoctors.com

PLEASE COMPLETE THIS FORM IN ITS ENTIRETY

Patient Name: _____ Date of Birth: ____/____/____ Age: _____

Address: _____ City: _____ State: _____ ZIP: _____

Patient SS#: ____--____--____ Email: _____ Marital Status: **S M W D**

Cell Phone: (____) _____-_____ Home Phone: (____) _____-_____

Employer: _____ Occupation: _____ Office Phone: (____) _____-_____

Preferred Pharmacy: _____ Location: _____

How did you hear about us? _____

Race:
- ☐ White
- ☐ Asian
- ☐ Black or African American
- ☐ Pacific Islander
- ☐ American Indian/Alaska-Native
- ☐ Native Hawaiian or Other

Ethnicity:
- ☐ Not Hispanic or Latino
- ☐ Hispanic or Latino
- ☐ Unknown
- ☐ Other: _____

Contact Preference:
- ☐ Cell Phone
- ☐ Home Phone
- ☐ E-mail
- ☐ Work

Is this visit due to an accident:
☐ Yes ☐ No
Type of accident:
☐ Auto ☐ Work ☐ Other

Special Needs:
☐ Hearing Impaired ☐ Translator

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

Policy Holder's Name: _____ Patient's Relationship to Policy Holder: _____

Policy Holder's Date of Birth: _____ Employer's Name: _____

Emergency Contact Name: _____ Relationship: _____

Cell Phone: (____) _____-_____ Home Phone: (____) _____-_____

Next of Kin Name: _____ Relationship: _____ Phone: (____) _____-_____

Signature: _____ **Date**: ____/____/____

Guardian Name (if applicable): _____