LEESTMA HEALTHCARE

519 N. Halleck
DeMotte, IN 46310
Phone: 219-987-7750, Fax: 219-987-5750

PATIENT REGISTRATION

Date_____________ Patient's Name __________________________________Home Phone __________________

SS# __________________________ Birthdate ______________________ Cell Phone _________________________

Address ____

City ___________________________________ State _____________________ Zip ____________________________

Email Address ____

Marital Status (check one) _____Single _____Married ______Widowed _____Divorced

______ Male _____Female

Please tell us how you heard of Leestma Healthcare____

INSURANCE SUBSCRIBER INFORMATION

Name____ Relationship to Patient______________________

Address____ Home Phone _______________________________

City___________________________________ State______________________ Zip____________________________

SS# _______________________________ Birthdate____________________ Occupation________________________

Employer____ Work Phone_______________________________

INSURANCE INFORMATION

PRIMARY Insurance Name_______________________________ Subscriber Name____________________________

ID#____ Group #___________________________________

SECONDARY Insurance Name____________________________Subscriber Name____________________________

ID#____ Group #___________________________________

Please list someone, other than spouse; we can call in case of emergency:

Name____ Relationship________________ Phone_________________

All services provided in the office are due and payable at the time of service.
Please give the receptionist your insurance card so that it may be copied and kept in your file.