

24 HR Lifeline MD  
12640 Twelve Mile Rd, Warren, MI 48093  
586-751-2020 Main  
586-745-1756 Fax

**Patient Registration & Demographics**

**Patient Name:** \_\_\_\_\_ Social Security # \_\_\_\_\_

Street Address: \_\_\_\_\_  
Last First MI City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Ph: \_\_\_\_\_ Work Ph: \_\_\_\_\_ Cell Ph: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Drivers Lic: \_\_\_\_\_

(Under 18)

**Mother's/Wife Name:** \_\_\_\_\_ Social Security # \_\_\_\_\_

Street Address: \_\_\_\_\_  
Last First City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Ph: \_\_\_\_\_ Work Ph: \_\_\_\_\_ Cell Ph: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Marital Status: \_\_\_\_\_

(Under 18)

**Father's/Husband Name:** \_\_\_\_\_ Social Security # \_\_\_\_\_

Street Address: \_\_\_\_\_  
Last First City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Ph: \_\_\_\_\_ Work Ph: \_\_\_\_\_ Cell Ph: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Marital Status: \_\_\_\_\_

**Primary Insurance:** \_\_\_\_\_ Phone: \_\_\_\_\_

Policy Holder's Name \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_ Sex: \_\_\_\_\_

DOB: \_\_\_\_\_ Policy Holder's Employer: \_\_\_\_\_ Phone: \_\_\_\_\_

Subscriber ID# \_\_\_\_\_ Group: \_\_\_\_\_

**Secondary Insurance:** \_\_\_\_\_ Phone: \_\_\_\_\_

Policy Holder's Name \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_ Sex: \_\_\_\_\_

DOB: \_\_\_\_\_ Policy Holder's Employer: \_\_\_\_\_ Phone: \_\_\_\_\_

Subscriber ID# \_\_\_\_\_ Group: \_\_\_\_\_

**Emergency Contact Name:** \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

I hereby assign medical benefits due to me to be paid to 24HR Lifeline MD. I hereby consent to the release of medical information necessary to process my insurance claims and to any other doctor for continuation of my medical care. I understand that a photocopy of this release is as valid as the original.

\_\_\_\_\_  
Signature of Patient, Parent or Guardian

\_\_\_\_\_