LEXINGTON MEDICAL CENTER

PEDIATRIC PATIENT INFORMATION (please print clearly and complete all 3 pages of form)

Date: _____ **SS#:**_____

Patient Name: _____

(Last) (First) (MI)

Maiden/Other Name: _____

(Last) (First) (MI)

Address: _____

Apt./Lot: _____ **City:** _____

County: _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Work Phone:** _____ **Cell Phone:** _____

Pager:_____ **Email:**_____

Date of Birth: _____ **Age:** _____ **Marital Status:** ☐ S ☐ M ☐ D ☐ W **Sex:** ☐ F ☐ M

Race: ☐ Decline to answer ☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Hispanic/Latino ☐ Native Hawaiian or other Pacific Island ☐ White ☐ More than one race

Ethnicity: ☐ Decline to Answer ☐ Hispanic or Latino ☐ Non Hispanic or Latino

Patient Speaks English: ☐ Yes ☐ No

Preferred Language: ☐ English ☐ Spanish ☐ Other_____

Preferred Communication Method: ☐ U.S. Mail ☐ E-Mail/Portal ☐ Home Phone ☐ Cell Phone ☐ Work Phone

Referred by: _____ **Primary Care Physician:**_____

Emergency Contact:_____ **Relationship:** _____

Home Phone: _____ **Work Phone:** _____ **Cell Phone:** _____

Patient's Religion: _____ **Living Will:** ☐ Yes ☐ No

Health Care Power of Attorney: ☐ Yes ☐ No **Organ Donor:** ☐ Yes ☐ No

Do you have medical insurance: ☐ Yes ☐ No

Next of Kin Name: _____

(Last) (First) (MI)

Relationship to patient:_____ **Home/Work Phone:** _____

Address: _____

City: _____ **State:**_____ **Zip:**_____

RESPONSIBLE PARTY INFORMATION

Responsible Party Name: _____
(Last) (First) (MI)

Address: _____

City: _____ **State:** _____ **Zip:** _____

Date of Birth: _____ **SS#:** _____ **Age:** _____

Relationship to Patient: _____ **Marital Status:** ☐ S ☐ M ☐ D ☐ W **Sex:** ☐ F ☐ M

Home Phone: _____ **Work Phone:** _____

PRIMARY INSURANCE TO FILE

Policy#: _____ **Group#/Group Name:** _____

Subscriber Date of Birth: _____ **Subscriber's Name:** _____

Relationship to Patient: _____

Subscriber's Address: _____

Subscriber's SSN or ID#: _____

Insurance Company Name: _____ **Insurance Phone:** _____

Insurance Address: _____

SECONDARY INSURANCE TO FILE

Policy#: _____ **Group#/Group Name:** _____

Subscriber Date of Birth: _____ **Subscriber's Name:** _____

Relationship to Patient: _____

Subscriber's Address: _____

Subscriber's SSN or ID#: _____

Insurance Company Name: _____ **Insurance Phone:** _____

Insurance Address: _____

PATIENT EMPLOYER INFORMATION

Employer/School: _____ **Occupation:** _____

Employer Address: _____

Employer Phone Number: _____ **Employment Status:** ☐ FT ☐ PT

ADDITIONAL GENERAL INFORMATION
(ONLY FOR THOSE PATIENTS 18 YEARS OLD OR YOUNGER)

Father's Name: _____ **Birth Date:** _____ **SS#:** _____

Employer: _____ **Phone:** _____

Mother's Name: _____ **Birth Date:** _____ **SS#:** _____

Employer: _____ **Phone:** _____

Names and birth dates for other children seen in this office:

Name: _____ **Birth Date:** _____ **Sex:** ☐ **Female** ☐ **Male**

Name: _____ **Birth Date:** _____ **Sex:** ☐ **Female** ☐ **Male**

Name: _____ **Birth Date:** _____ **Sex:** ☐ **Female** ☐ **Male**

I understand that payment is due at the time service is rendered. I hereby authorize the release of any medical information to (1) an insurance company through which I claim benefits and (2) any physician involved in my medical care. I realize the authorization allows LMC Physician Practices to release any information to any of my insurers or physicians.

I authorize and direct my insurers to pay directly to LMC Physician Practices and/or its physicians any and all benefits up to the amount of my bill pertaining to all charges incurred. I assign to LMC Physician Practices, including its affiliates, any and all benefits or proceeds, of any type whatsoever, to which I am entitled, with respect to the health care service(s) I receive, including but not limited to, the proceeds of any liability settlement or judgment being paid by or on behalf of a third-party and any benefits due from any third-party insurance policy. I direct that all such benefits be paid directly to LMC Physician Practices and/or its affiliates, including its physicians, and applied to my account(s) until the account(s) is paid in full. I understand that I am personally responsible for any remaining fees. I hereby agree to pay all costs and reasonable attorney fees in the event this account is turned over to an attorney for collection. I authorize LMC Physician Practices to contact me on any cell phone number provided by me for the purposes of conducting business with me or contacting me concerning my account. I consent to the use of automated dialers for that purpose. I understand that I am financially responsible to LMC Physician Practices for all charges not covered, approved or considered necessary by my insurance company. I will pay at the time of service or have an agreeable payment arrangement set up with the business office.

Signature: _____ **Date:** _____

Signature: _____ **Date:** _____

Responsible Party Signature (if different)