Lexington Health

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*:** _____

**** By providing us with your current e-mail address, you will receive an invitation to join the LMC Patient Portal.***

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

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

Race: ☐ Decline to answer ☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or other Pacific Island ☐ White

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:** _____

Signature: _____ **Date:** _____

Signature: _____ **Date:** _____

Responsible Party Signature (if different)