Chart # ____________

LEXINGTON FAMILY PHYSICIANS
102 WEST MEDICAL PARK DRIVE
LEXINGTON, NC 27292
Phone-(336) 249-3329
Fax-(336) 249-3795

Demographics

*Patient Name: _________________________ *Date of Birth: _______ *Sex: _____ *Race ______

*Ethnicity: Hispanic/Latino _____ Non-Hispanic/Latino _____ Other or Undetermined ______

*Language: _________________________

*Address: ____
(Street) (City) (State) (Zip)

Maiden Name: __________________________ Mothers First Name: ________________________

*Home Phone # ____________________________ *Work Phone # __________________________

Marital Status: S M D W SEP

Employer: _______________________________ Address: __________________________________

*E-mail: ____

Spouse: __________________________________ Date of Birth: ______________________________

Work Phone # _____________________________ Address: __________________________________

*Person Responsible for Payment: ____

*Insurance Company & Number: ____
Policyholders Name: ____

*Secondary Insurance Co. & Number: ____
Policyholders Name: ____
Medicare Number: ___________________________
Medicaid Number: ___________________________
Whom may we contact in case of emergency (other than spouse)?

*Name: ____________________________________ Telephone # ____________________________

I authorized the release of medical records to my insurance carrier, and to other providers to whom I am referred. I request payment of authorized insurance benefits be made on my behalf to Lexington Family Physicians, PA, or to me if assignment is not accepted. I understand that I am financially responsible for services not covered by my insurance. However, I am responsible to pay my portion of my bill at the time of service

*Signature: ____ Date: _________________________