LEXINGTON MEDICAL CENTER

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)