Chart # _____

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

Adult Patient Form

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 # _____

Social Security # _____ 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: _____