CHART # _____

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

Child Patient Form

Child's Name_____ Sex: _____ Race _____

Ethnicity: Hispanic/Latino _____ Non Hispanic/Latino _____ Other or Undetermined ____

Language: _____

Social Security # _____ Date of Birth: _____

Mother's Name: _____ Date of Birth: _____

Address: _____
(Street) (City) (State) (Zip)

Home Telephone # _____ Work Telephone # _____

Social Security # _____ Marital Status S M D W SEP

Employer: _____ Address: _____

E-mail: _____

Father's Name: _____ Date of Birth: _____

Social Security # _____ Employer: _____

Work Phone # _____ Address: _____

Person Responsible for payment: _____

Insurance Company and Number/Medicaid: _____
Policy Holder's Name: _____

Whom may we contact in case of emergency other than parent(s)?

Name: _____ Telephone # _____

I authorize the release of medical records to my insurance carrier, if needed to process claims. 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. <u>You are requested to pay at the time of service.</u>

Signature: _____ Date: _____