



Patient Registration Form

Patient information

Last name: _____

First name: _____ Middle initial: _____

Date of birth: _____ Male Female

Address: _____ Apt #: _____

City: _____ State: _____ Zip: _____

Race: _____

Ethnicity: Not Hispanic, Latino or Spanish origin Unknown
 Hispanic, Latino or Spanish origin Decline to answer

Needs interpreter: No Yes Language: _____

Form confidence: Very confident Confident
 Not confident Decline to answer

Visually impaired: No Yes

Hearing impaired: No Yes

Pharmacy: _____

New primary care physician at Lexington Pediatrics:

Parent/Guardian information

Parent/Guardian #1: _____

Home phone: _____

Can message be left? Yes No

Message type: Brief Extended

Cell phone: _____

Can message be left? Yes No

Message type: Brief Extended

Can we text you? Yes No

Email: _____

Parent/Guardian #2: _____

Person responsible for bill

Last name: _____

First name: _____ Middle initial: _____

Date of birth: _____ Relation: _____

Address: _____ Apt #: _____

City: _____ State: _____ Zip: _____

Home phone: _____ Cell phone: _____

Medical insurance information

Copy of insurance card required to file insurance.

Policy holder last name: _____

Policy holder first name: _____

Insurance name: _____

Certificate #: _____

Group #: _____

Member #: _____

Other children

Last name: _____

First name: _____ Middle initial: _____

Date of birth: _____ Male Female

Last name: _____

First name: _____ Middle initial: _____

Date of birth: _____ Male Female

Last name: _____

First name: _____ Middle initial: _____

Date of birth: _____ Male Female

How did you hear of us?

Family/friend Web search Social media
 Print advertisement Other

Assignment of benefits and release of information

I hereby authorize my insurance benefits to be paid to Lexington Pediatrics and acknowledge that I am responsible for any balance not covered by those benefits. I authorize Lexington Pediatrics to release information requested concerning my care to insurers paying such benefits.

Signature: _____