



# 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: \_\_\_\_\_