LEXINGTON OB GYN
Associates

REGISTRATION FORM

Appointment Date: Doctor being seen: PCP:

PATIENT INFORMATION

Patient's Name

Last: _____ First: _____ Middle: _____

Marital status (Circle): Single Mar Div Sep Widow

Birth date:_____ Age: _____ Social Security #: _____

Address: _____ Apt #: _____

City: _____ State: _____ ZIP Code: _____

Home phone # :( )_____ Cell phone # : ( )_____

Email Address:_____

Preferred Pharmacy:_____ Location: _____Phone # _____

Occupation:_____ Employer: _____Employer phone # : ( )_____

Spouse's Name:_____Spouse's Birthday: _____

Spouse's Employer: _____ Spouse's Employers phone #: ( ) _____

Other family members seen here: _____

INSURANCE INFORMATION

Please indicate primary insurance : _____ Insurance Phone # _____

Subscriber's name: _____

Subscriber's S.S. # : _____ Birth date: _____Group #: _____Policy (ID)#:_____

Co-Payment: $ _____

Patient's relationship to subscriber (Circle): Self Spouse Child Other

Name of secondary insurance (if applicable): _____Insurance Phone #_____

Subscriber's Name: _____

Subscriber's S.S. #: _____ Birth Date: _____Group #: _____ Policy (ID)#: _____

Co-Payment: $ _____

Patient's relationship to subscriber (Circle): Self Spouse Child Other

IN CASE OF EMERGENCY

Name Of Contact: _____ Relationship to Patient: _____

Home Phone # _____Work Phone # _____ Birth Date: _____

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Lexington OBGYN Associates or insurance company to release any information required to process my claims.

Patient/Guardian signature Date