☐ **Owensboro Heart & Vascular**
☐ **Owensboro Primary Care**
☐ **Immediate Care Center**
☐ **Owensboro Advanced Sleep Center**
☐ **Owensboro Medical Practice Laboratory**
☐ **Owensboro Neurology**
☐ **Rejuve Medical Spa**
☐ **Research Integrity**
☐ **The McLean Clinic**
☐ **The Muhlenberg Clinic**
☐ **Tristate Diagnostic Laboratory**
☐ **VORA Wound Healing Center**

OWENSBORO
Medical Practice

Name: _____

DOB: _____

MR#: _____

Date: _____

Dear Valued Patient:

Welcome to our office. We are committed to providing the best, most comprehensive care possible. We encourage you to ask questions. Please assist us by providing the following information (please print). All information is confidential and is only released with your consent.

PATIENT INFORMATION

Patient Last Name _____ First Name _____ Middle _____ Nickname _____

Social Security _____-____-_____ Birth Date ___/___/____ Sex _____

ADDRESSES

Billing: Street/PO Box _____ Apt _____ City _____

State _____ Zip _____ Country _____ County _____

Secondary: Street/PO Box _____ Apt _____ City _____

State _____ Zip _____ Country _____ County _____

CONTACT METHOD

Home Phone (____) ____-_____ Day Phone (____) ____-_____ Alternate Phone (____) ____-_____

E-mail _____ Cell Phone (____) ____-_____ Preferred Contact Method_____

By providing my e-mail address, I acknowledge that I may receive health surveys and other health care related communications. I understand this is not to be used for provider communication.

DEMOGRAPHICS

Marital Status	☐ Single	☐ Married	☐ Divorced	☐ Widowed	☐ Separated
Student Status	☐ None	☐ Full-Time	☐ Part-Time	☐ Not a Student	
Race	☐ African American	☐ American Indian	☐ Asian	☐ Hispanic	☐ Indian
	☐ Multiracial	☐ Native American Indian		☐ Unknown / non-specific	☐ White
Ethnicity	☐ Declined to Specify	☐ Hispanic or Latino		☐ Not Hispanic or Latino	☐ Other

Preferred Language _____ Religion _____

Primary Care Provider _____ Provider Phone _____

Referring Provider _____ Referring Provider Phone _____

Primary Dental Provider _____ Dental Phone _____

Preferred Pharmacy _____ Pharmacy Phone _____

Pharmacy Address, City, State, Zip _____

Alternative Pharmacy _____ Alternate Pharmacy Phone_____

Alternate Pharmacy Address, City, State, Zip_____

Smoker ☐ yes ☐ no Veteran ☐ yes ☐ no

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Emergency Contact (someone other than a parent and who does not live with the patient or a parent)

Name _____ Relationship _____ Phone _____

Employment Status _____ **Employer Name** _____

Employer Phone _____ Employer Street Address _____

Employer City, State, Zip _____

Parent/Guardian(s) or Spouse Information #1 Name _____

Relationship to Patient _____ SSN _____ Date of Birth _____

Street _____ Apt _____

City, State, Zip _____

Parent/Guardian(s) or Spouse Information #2 Name _____

Relationship to Patient _____ SSN _____ Date of Birth _____

Street _____ Apt _____

City, State, Zip _____

Medical Insurance Info	Primary Insurance	Secondary Insurance
Subscriber ID		
Group or Plan Number		
Plan / Program Code		
Insurance Co. Name		
Insurance Co. Phone Number		
Patient Relation to Subscriber		
Subscriber Name		
Subscriber Street Address		
Subscriber City and State		
Subscriber Zip Code		
Subscriber Date of Birth		
Subscriber Gender		
Subscriber Social Security #		
Subscriber Employer		
Co-Pay Amount		

Injury Related Information ☐ Work ☐ Auto ☐ Motorcycle ☐Other

Date & Time of Injury _____

State Where Injury Occurred _____ Claim Number _____

Have you informed your Employer? ☐ Yes ☐ No Contact Name _____

Worker's Compensation / Auto Insurance Carrier Name _____

Insurance Co. Address, City, St, Zip _____

_____ _____

Patient / Parent / Legal Guardian / Legal Authorized Representative Signature **Date**

If Parent / Legal Guardian / Legal Authorized Representative, Print Name _____