

- 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



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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Name: _____
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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 _____