

# Ballard County Medical Clinic

120 South 4th Street • P.O. Box 250 • Barlow, Kentucky 42024 • Main 270-334-3131 • Fax 270-334-3173

It is a pleasure to welcome you to our office. Please complete both sides of this form to aid us in preparing or updating your clinical records. Of course, all information given to us will be strictly confidential. Please have your insurance cards available in order to make copies. This office will process your primary insurance and provide information to you for any additional insurances.

(Please Print)

DATE FORM COMPLETED: \_\_\_\_\_ REFERRED TO THIS OFFICE BY: \_\_\_\_\_

\_\_\_\_ Mr. \_\_\_\_ Ms. \_\_\_\_ Mrs. \_\_\_\_ Child \_\_\_\_\_  
(Patient's full name, do not use initials or nicknames)

PATIENT'S ADDRESS: \_\_\_\_\_  
(Street and Number, City, State, Zip Code)

SOCIAL SECURITY #: \_\_\_\_\_ PHONE: (Daytime) \_\_\_\_\_ (PM) \_\_\_\_\_

(If patient is a minor, full name, address and phone number of responsible party)

PATIENT'S AGE: \_\_\_\_\_ PATIENT'S DATE OF BIRTH: \_\_\_\_\_ MARITAL STATUS: \_\_\_\_\_

PATIENT'S EMPLOYER: \_\_\_\_\_ OCCUPATION: \_\_\_\_\_

EMPLOYER'S ADDRESS: \_\_\_\_\_ EMPLOYER'S PHONE: \_\_\_\_\_

SPOUSE'S NAME: \_\_\_\_\_ SS #: \_\_\_\_\_ DOB: \_\_\_\_\_

SPOUSE'S EMPLOYER: \_\_\_\_\_ OCCUPATION: \_\_\_\_\_

EMPLOYER'S ADDRESS: \_\_\_\_\_ EMPLOYER'S PHONE: \_\_\_\_\_

INS. CO. (PRIMARY): \_\_\_\_\_ POLICY #: \_\_\_\_\_

INS. CO. (SECONDARY): \_\_\_\_\_ POLICY #: \_\_\_\_\_

If your insurance is NOT Medicare or Kentucky Medicaid, please fill out the following insurance information.

PRIMARY CLAIM ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

NEAREST RELATIVE: \_\_\_\_\_ PHONE NUMBER: \_\_\_\_\_  
(Not living at patient's address)

RELATIONSHIP: \_\_\_\_\_ ADDRESS: \_\_\_\_\_

Is your visit to this office the result of an on the job injury? \_\_\_\_ Yes \_\_\_\_ No

Name of the person to contact and phone number to verify injury: \_\_\_\_\_

Have you been treated by any of our doctors previously? \_\_\_\_\_ Date last seen: \_\_\_\_\_

Name of Pharmacy: \_\_\_\_\_ Address: \_\_\_\_\_ Phone #: \_\_\_\_\_

Reason for this visit: \_\_\_\_\_

I understand I am responsible for all charges that result from services rendered to me by the physician of **Ballard County Medical Clinic**. I hereby authorize payment to be made directly to me or in the case of assignment to the **Ballard County Medical Clinic** physician rendering services. I also authorize release of pertinent medical information to the insurance carrier.

\_\_\_\_\_  
(Guarantor's Signature)

\_\_\_\_\_  
(Date)

# Ballard County Medical Clinic

Patient Name \_\_\_\_\_ Today's Date \_\_\_\_\_

Date of Birth \_\_\_\_\_ Physician \_\_\_\_\_

Reason for visit \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

List all current meds and dosages: _____	List all medication allergies and reaction that occurs: _____	List all chronic medical problems and surgeries: _____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Family History** (circle all that apply)

Mother: Living Deceased (age and cause of death) \_\_\_\_\_

High Blood Pressure Diabetes Heart Disease Stroke Cancer Other \_\_\_\_\_

Father: Living Deceased (age and cause of death) \_\_\_\_\_

High Blood Pressure Diabetes Heart Disease Stroke Cancer Other \_\_\_\_\_

Brothers (number of) \_\_\_\_\_ Sisters (number of) \_\_\_\_\_

Health problems in any siblings:

High Blood Pressure Diabetes Heart Disease Stroke Cancer Other \_\_\_\_\_

**Social History** (circle reply)

Marital Status S M W D Number of children \_\_\_\_\_

Cigarette Use No Yes How much per day? \_\_\_\_\_

Alcohol Use No Yes How much per week? \_\_\_\_\_

Employed No Yes Type of work? \_\_\_\_\_

Physician \_\_\_\_\_ Date \_\_\_\_\_