Internal Medicine Group

P.O. Box 7448 • Paducah, KY 42002-7448
www.internalmedicinegroup.com

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: ____

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

____ ____
(Guarantor's Signature) **(Date)**

JP-008

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