

Paducah Family Medicine
225 Medical Center Drive, Suite 302 • Paducah, KY 42003

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 **Paducah Family Medicine**. I hereby authorize payment to be made directly to me or in the case of assignment to the **Paducah Family Medicine** physician rendering services. I also authorize release of pertinent medical information to the insurance carrier.

(Guarantor's Signature)

(Date)

