

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: _____

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: _____ MALE OR FEMALE: _____

LIST OF SIBLINGS: _____ DOB: _____ MALE OR FEMALE: _____

SIBLINGS: _____ DOB: _____ MALE OR FEMALE: _____

SIBLINGS: _____ DOB: _____ MALE OR FEMALE: _____

EMPLOYER: _____ EMPLOYER'S PHONE: _____

INSURANCE HOLDER'S NAME: _____ SS #: _____ DOB: _____

INSURANCE HOLDER'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: _____

PARENT'S NAME: _____ OCCUPATION: _____

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)

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Consent for Medical Treatment of a Minor Child

I, _____, of (City) _____, (State) _____,
do hereby state that I am the parent or legal guardian of _____, a
minor, age _____, born on _____/_____/_____, who resides with me at (current address)

I authorize _____, an adult in whose care the minor child has
been entrusted and who resides at (address) _____ to
consent to and authorize any necessary examinations, x-rays, anesthetic, medical or special supervision
and on the advice of any physicians or surgeons and or medical personnel at Paducah Family Medicine.

***This consent shall be in effect from the date of execution and shall be effective until or unless
revoked and terminated by my written notice to Paducah Family Medicine at any time I deem
necessary.***

By signing below I indicate that I have the understanding and capacity to communicate health care
decisions and that I am fully informed as to the contents of this document and understand the full import
of the grant of powers to the agent named herein.

Signature of Custodial Parent / Legal Guardian

Date

Signature of Witness

Date