KENTUCKY CARDIOLOGY, PLLC

Date: _____

PATIENT DEMOGRAPHIC INFORMATION

First Name: _____ Middle: _____ Last Name: _____

DOB: _____/_____/_____ SSN: _____-_____-_____ Sex: □ Female □ Male

Marital Status: □ Married □ Single □ Widowed □ Divorced

Race: □ American Indian/Alaska Native □ Asian □ Black/African American
□ Nat Hawaiian/Pacific Islander □ White □ Unknown □ Other_____
□ Declined

Ethnicity: □ Hispanic/Latino □ Not Hispanic/Latino □ Unknown □ Declined

Home Phone: ( ) _____-_____ Work Phone: ( ) _____-_____ Cell Phone: ( ) _____-_____

Patient Email Address: _____

Physical Home Address:_____City:_____ State_____ Zip_____

Mailing Address:_____City:_____ State_____ Zip_____

Occupation: _____ □ Employed □ Retired □ Full-Time Student □ Disabled □ Unemployed

Employer: _____ Address: _____

Family Physician: _____ Phone: ( ) _____-_____

Referring Physician: _____ Phone: ( ) _____-_____

Pharmacy Name: _____City/State: _____ Phone: ( ) _____-_____

Emergency Contact Name & Relationship: _____Phone ( ) _____-_____

INSURANCE INFORMATION

#1 Insurance Name: _____ ID#: _____ Group#: _____

Subscriber Name: _____ DOB: _____ SS# _____-____-_____

Relationship to Patient: _____

#2 Insurance Name: _____ ID#: _____ Group#: _____

Subscriber Name:_____ DOB: _____ SS# _____-____-_____

Relationship to Patient: _____

If someone other than patient is responsible for payment of medical bills, please list here:

Name: _____ DOB: _____/_____/_____

SSN: _____-_____-_____ (*Insurance companies require this information for claim processing)*

Address: _____ Phone: ( ) _____-_____

Revised 4/11/12

KENTUCKY CARDIOLOGY, PLLC

Patient Name: _____ D.O.B.: _____/_____/_____

How would you like to receive you appointment reminders? Please circle one or more:

Phone call *text message *email

*Please make sure that you have given us your email address or cell phone number if you chose this as your method of appointment notification.

PATIENT AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

By signing this authorization, I authorize Kentucky Cardiology to obtain a copy of my medical records from my primary care physician, treating hospital, or any other medical facility/provider as deemed necessary by Kentucky Cardiology.

_____
Print

_____
Signature

_____
Date