□ **Owensboro Heart & Vascular**
□ **Owensboro Primary Care**
□ **Immediate Care Center**
□ **Owensboro Advanced Sleep Center**
□ **Owensboro Physical Therapy**
□ **Owensboro Medical Practice Laboratory**
□ **Rejuve Aesthetics & Wellness**
□ **Research Integrity**

OWENSBORO
Medical Practice

DATE: _____

MRN#: _____

□ **The Hancock Clinic**
□ **The McLean Clinic**
□ **The Muhlenberg Clinic**

Dear Valued Patient,

Welcome to our office. We are committed to providing the best, most comprehensive care possible. We encourage you to ask questions. Please assist us by providing the following information in PRINT. All Information is Confidential and is only released with consent.

PATIENT INFORMATION

Patient Name			Date of Birth	Sex Age
Patient's Social Security Number	Home Telephone Number		Cell Phone Number	
Home Address	City	State	Zip	
Mailing Address if Different	City	State	Zip	
Race: Asian Black/African American More than one race Native Hawaiian or other pacific Islander Other Race Unknown White Hispanic/Latino				
Please Circle all that apply: Married Widowed Single Separated Minor Student Smoker Veteran				
Preferred Language	Primary Care Physician		Email Address	
Employer's Name	Work Telephone Number		Driver's License No.	
Employer's Address	City	State	Zip	

LEGAL GUARDIAN/SPOUSE INFORMATION

Legal Guardian/Spouse Name	Social Security Number		Date of Birth
Employer's Name		Work Telephone Number	
Employer's Address	City	State	Zip

NOTIFY IN CASE OF EMERGENCY

Contact Name (not living with you)	Relationship	Contact Name	Relationship
Home Telephone Number	Date of Birth	Home Telephone Number	Date of Birth

POLICY HOLDER INSURANCE INFORMATION

Primary Policy Holder Name		Secondary Policy Holder Name	
Social Security Number	Date of Birth	Social Security Number	Date of Birth
Name of Insurance	ID/Group Number	Name of Insurance	ID/Group Number
Phone Number		Phone Number	

ACCIDENT INFORMATION

Were You Injured on the Job? YES NO		Were you involved in an Auto Accident? YES NO	
Have you Informed Your Employer? YES NO		Claim Number:	
Original Injury Date:		Time of Injury:	State Injury Occurred:
Worker's Compensation/Auto Insurance Carrier Name		Billing Address	

AUTHORIZATIONS

I hereby authorize examination and any other medical services deemed necessary. I authorize Owensboro Medical Practice to forward results of any tests and/or medical services to medical facilities or insurance companies including Workers Compensations that they may require concerning my case. I authorize and request my insurance company/companies to pay directly to Owensboro Medical Practice, PLLC, the amount due them in my pending claim for medical, surgical or laboratory services. I understand any balance remaining after insurance payment or denial is my responsibility and that interest may be charged on accounts due past 90 days. I agree my records may be used and reviewed during research and quality assurance programs. I hereby release Owensboro Medical Practice from liability for any loss or damage to property which is brought to or kept in the facility during treatment.

DATE_____**SIGNATURE**_____**PRINTED**_____