PATIENT DEMOGRAPHIC FORM - Kentucky Pain Associates

Date: ____/_____/_____ **Patient Name: Last**:_____ **First**:_____ **MI**:____

Address: _____ **Zip Code**: _____ **City**:_____ **State**:____

Date of Birth: _____/_____/_____ **Age:** _____ **Minor? (circle):** Yes / No **Gender (Circle):** M / F

Marital Status (Circle): Single Married Divorced Widow Separated

Social Security: _____ -____ -_____ **Primary Phone:** (_____) _____-_____ **Cell Phone:** (_____) _____-_____

Email:_____@_____ **Is this Injury/Illness due to (Circle):** Auto Accident Other

Date of Accident: _____/_____/_____ **State**: ____ **Was the Vehicle a Rental Car? (circle)** Yes / No

Patient Resides With (Circle): Alone Spouse Parents Children Other_____

Do you own a vehicle (Circle)? Yes No **Do any household family members own a vehicle (Circle)?** Yes No

PLEASE PRESENT INSURANCE CARDS AND PHOTO ID TO THE RECEPTIONIST SO COPIES MAY BE MADE.

CONSENT TO TREAT

The need for diagnostic testing and/or procedure has been thoroughly explained to me and I **agree** to have the testing performed in this office. I further understand my treating physician will arrange an acceptable payment plan for any cost not covered by my insurance.

X_____ _____/_____/_____

Patient or Responsible Party Signature *Date*

AUTHORIZATION, RELEASE & AGREEMENT TO PAY FOR SERVICES RENDERED.

I authorize the doctor and other health-care professionals (clinical staff) to perform diagnostic procedures and treatment as may be necessary for proper medical care. I authorize Kentucky Pain Associates to release any medical information including the diagnosis and the records of any treatment or examination rendered to me/my child during the period of such care to third party payers, and other entities and/or health practitioners. I authorize and assign directly to Kentucky Pain Associates all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance.

X_____ _____/_____/_____

Patient or Responsible Party Signature *Date*

In order to help us stay within the guidelines of HIPAA, please list any person(s) that you authorize us to speak with about your medical condition. You do not need to list any of your physicians.

1) Name: _____ Relationship:_____

2) Name: _____ Relationship:_____

3) Name: _____ Relationship:_____

Do we have your permission to leave messages regarding information (such as appointment reminders or requests to call the office) when you are not home? (Circle One): YES NO

Do we have your permission to call you at the listed secondary phone number? (Circle One): YES NO

Do we have your permission to email you with important information and/or periodic updates? (Circle One): YES NO

We respect your privacy and will never share it with anyone.

By signing below you agree that you have read the HIPAA guidelines posted in the office. If you would like a copy of the guidelines one will be provided to you.

X_____ _____/_____/_____

Patient Name (PLEASE PRINT) *Today's Date*

X_____

Patient Signature

Revised: 04/28/15 - KR