Referred from: ____
(Print Name of Referring Clinic/Facility) (Clinic/Facility Phone Number)
Referring Provider's Name: _________________________________
(Print Referring Provider's Name)

Referred to: Kentucky Pain Associates, PLLC

Phone: 502-855-3907 Fax: 502-561-3162 Hours: M-F, 9:00am – 12:30pm, 1:30pm – 5pm

Appointment Time: ____________________ Date: ________________________

Patient Information: ***Must bring Photo ID*** SS#: _________________________________

Name: _____________________________________ Date of Birth:_____________________________

Address: ____ City:_________________________

ST: __________ ZIP: ___________ Phone: ___________________________ Sex: M or F

Marital Status: _____ Single _____ Married Primary Language: ______________________________

Accident Information

Injury is due to:
______Auto Accident
______Work Related (Worker's Comp)
______Chronic Pain
______Slip and Fall

Date of Accident Causing Injury: ____________________

If it was an auto accident, describe the vehicle type:
______Owned/Leased
______Rental Car
______TARC
______Taxi/Uber/Lyft

Insurance Information:

Ins. Co. Name: ____ Phone: _________________________

Claim#: ____

Attorney Information:

Attorney Name: _____________________________________ Phone: _________________________

Referring Provider's Diagnosis (Please attach all imaging reports):

Diagnostic Studies/Results: ____

MRI Results: ____

X-ray Results: ____

DMX Analysis Results: ____

Other Studies/Results: ____

Referring Provider's Plan of Care: ____