



624 Chamberlin Avenue
Frankfort, KY 40601

Phone: (502) 226-5454
FAX: (859) 226-2265

Registration and Demographics

This information will be kept confidential.

Date Completed : _____ Preferred Provider: _____

PATIENT INFORMATION						
NAME	Last	First	Middle	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth	Social Security #
Home Phone #				Cell Phone #	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Divorced	
Maiden Name	Place of Birth	Home Address		City	State	ZIP
E-Mail Address	Emergency Contact:		Name	Phone	Relationship	
Responsible Party's Employer's Name			Address	City	State	ZIP
Work Phone						
Education: Check highest level completed <input type="checkbox"/> Grade School <input type="checkbox"/> Jr. High <input type="checkbox"/> High School / GED <input type="checkbox"/> College <input type="checkbox"/> Graduate School						
IF CLIENT IS A MINOR, PLEASE COMPLETE THE FOLLOWING.				Is this a foster child? <input type="checkbox"/> Yes <input type="checkbox"/> No		
(Circle One) Mother's Name / Guardian's Name (1)/Daytime Phone #				Father's Name / Guardian's Name (2)/Daytime Phone #		
INSURANCE INFORMATION <input type="checkbox"/> Patient <input type="checkbox"/> Parent/Responsible Party						
Name: _____ SSN: _____ DOB: _____						
Please Choose One Of The Following:						
<input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> Private <input type="checkbox"/> Self-Pay						
Authorization for Release of Medical Information:						
Please list below the individuals with whom we have your permission to discuss the content of your entire medical file. (Please Print)						
	<u>Name</u>		<u>Relationship</u>		<u>Telephone</u>	
1.	_____		_____		(____) _____	
2.	_____		_____		(____) _____	
3.	_____		_____		(____) _____	
I understand that I have the right to revoke this authorization at any time by providing Primary Care Express - Frankfort with written notification. I also understand that any revocation shall be effective the date it is included in the medical record and will not be retroactive.						
Signature: _____ Date: _____						