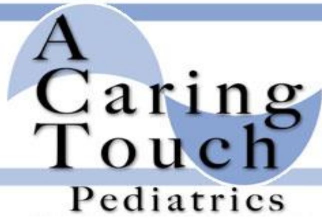

230 Fountain Court, Suite 260
Lexington, KY 40509
859-264-0660 Voice
859-264-0662 Fax

PATIENT REGISTRATION FORM

Patient Information

Name:____ Prefers to be called:________________

Date of birth:______________________________ Gender: M F SSN:_____________________

Address:_________________________ City:____________________ State:_______ Zip:________

We have an automated phone calling service. Which number would like to get your voice reminders on?

Primary Phone:____________________________ Secondary Phone: ___________________________

(This is the number that will be called for reminders.)

Family Information

Parent/Guardian #1

Name: ____ Relationship to pt:__________________

Date of birth: _____________________________ SSN:______________________________

Address:_________________________ City:____________________ State:_______ Zip:________

Primary Phone: ____________________________ Secondary Phone:___________________________

Email:____________________________________

Parent/Guardian #2

Name: ____ Relationship to pt:__________________

Date of birth: _____________________________ SSN:______________________________

Address:_________________________ City:____________________ State:_______ Zip:________

Primary Phone: ____________________________ Secondary Phone:___________________________

Email:____________________________________

Siblings and dates of birth:

____ ____

____ ____

____ ____

****** INSURANCE CARDS ARE REQUIRED AT EVERY VISIT ******