



OWENSBORO
Medical Practice

- Owensboro Heart & Vascular
- Owensboro Primary Care
- Immediate Care Center
- The Hancock Clinic
- The McLean Clinic
- The Muhlenberg Clinic
- Owensboro Advanced Sleep Center
- Owensboro Physical Therapy

DATE: _____

CHART #: _____

PATIENT INFORMATION

Patient Last Name: _____ First: _____ MI: _____

Address: _____ City _____ State _____ Zip _____

Date of Birth: _____ Social Security No.: ____/____/____ Sex: M F

Home Phone: (____) _____ Cell:(____) _____

Employer Name: _____ Occupation: _____

Employer Address: _____ City _____ State _____ Zip _____

Employer Phone: (____) _____

Married Divorced Widowed Single Spouse's Name: _____

Referring Dr.: _____ Primary Care Dr: _____

Are you here due to an accident? Yes No - If yes, what type? Auto Work Related Other

Do you have a Living Will? No Yes (If yes, please provide a copy for your record)

INSURANCE INFORMATION

Insured Name: _____ Insured Date of Birth: _____

Insured Social Security Number: ____/____/____ Insured Phone: (____) _____

Insured Employer Name: _____ Occupation: _____

Insured Employer Address: _____ City: _____ State: _____ Zip: _____

Insured Employer Phone Number: (____) _____

EMERGENCY CONTACT INFORMATION

First Emergency Contact:

Name: _____ Phone Number: (____) _____

Relationship To Patient: _____

Second Emergency Contact:

Name: _____ Phone Number: (____) _____

Relationship to Patient: _____

SIGNATURE PLEASE – ASSIGNMENT AND RELEASE

I hereby authorize examination and any other medical services deemed necessary. I authorize Owensboro Medical Practice to forward the results of any tests and/or medical services to medical facilities (primary care providers, referring physicians, hospitals, etc) or insurance company/ companies including Worker’s Compensation that they may require concerning my case. I hereby authorize and request my insurance company/companies to pay directly to Owensboro Medical Practice, PLLC, the amount due to them in my pending claim for medical or surgical treatment services. I understand that my insurance is a contract between myself and my insurance company, not between the insurance company and the provider. I understand that any balance remaining after my insurance pays or denies payment is my responsibility. Interest may be charged on accounts that are past due by 90 days or more at a rate of 1 1/2% per month or 18% per year. I agree my records may be used and reviewed during 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 my treatment.

DATE: _____

SIGNATURE: _____