PATIENT DEMOGRAPHIC INFORMATION

Patient First Name: _____ MI: _____ Last Name: _____

Maiden Name: _____ DOB: ____/_____/_____

SSN: _____-_____-_____ Sex: ☐Female ☐Male ☐ Other _____

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Domestic Partner ☐ Other: _____

Race: ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American
☐ Nat Hawaiian/Pacific Islander ☐ White ☐ Unknown ☐ Other_____ ☐ Declined

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Unknown ☐ Declined

Home Phone: ( ) _____-_____ Work Phone: ( ) _____-_____

Cell Phone: ( ) _____-_____

Patient Email Address: _____

Physical Home Address:_____City:_____ State_____
Zip_____

Mailing Address:_____City:_____ State_____
Zip_____

Occupation: _____ ☐ Employed ☐ Retired ☐ Full-Time Student ☐ Disabled ☐ Unemployed

Employer: _____ Address: _____

Family Physician: _____ Phone: ( ) _____-_____

Referring Physician: _____ Phone: ( ) _____-_____

Pharmacy Name: _____City/State: _____ Phone: ( ) _____-_____

Emergency Contact Name_____ Relationship_____Phone( )_____-_____

If someone other than patient is responsible for payment of medical bills, please list here:
Name: _____ DOB: ___/____/____ SSN: _____-_____-_____

PATIENT AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

By signing this form, I hereby authorize **Kentucky Cardiology** to obtain a copy of my medical records and/or films of any imaging studies from my primary care physician, treating hospital, or any other medical facility/provider as deemed necessary by Kentucky Cardiology. This release is good for 1 (one) year from date signed.

Patient Signature _____ Date _____

Revised 4/11/12