

OPEN MRI of KENTUCKY

Patient ID # _____

705 North 12th Street. – Middlesboro, KY 40965

PATIENT INFORMATION SHEET

DATE: _____ SOCIAL SECURITY#: _____ MARITAL STATUS: S M D W

NAME: _____ DATE OF BIRTH: _____ AGE: _____ SEX: M F

ADDRESS: _____ CITY _____ STATE _____ ZIP _____

HOME PHONE: _____ CELL PHONE: _____ WORK # : _____

IF PATIENT IS A MINOR(Under 18), PLEASE LIST PARENT OR GUARDIAN

FATHER/MOTHER _____ SS# _____ DOB _____

NAME OF REFERRING PHYSICIAN: _____ PHARMACY: _____

REASON FOR VISIT: _____ ALLERGIES: _____

CURRENT MEDICATIONS: _____

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Headaches 784.0 | <input type="checkbox"/> Shooting Pain Legs 724.4 | <input type="checkbox"/> Muscle Spasms 728.85 | <input type="checkbox"/> Lung Disease |
| <input type="checkbox"/> Dizziness 780.4 | <input type="checkbox"/> Leg Pain 729.5 | <input type="checkbox"/> Muscle Weakness 728.87 | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Neck Pain/Stiffness 723.1 | <input type="checkbox"/> Memory Loss 780.93 | <input type="checkbox"/> Muscle Cramps 729.82 | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Arm/Shoulder Pain 719.41 | <input type="checkbox"/> Ears Ringing 388.30 | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Pins/ Needles Arm 782.0 | <input type="checkbox"/> Blurred Vision 368.8 | <input type="checkbox"/> Angina | <input type="checkbox"/> Other |
| <input type="checkbox"/> Fainting 780.2 | <input type="checkbox"/> Upper Back Pain 724.1 | <input type="checkbox"/> Diabetes | |
| <input type="checkbox"/> Numbness/ Tingling 782.0 | <input type="checkbox"/> Mid Back Pain 724.1 | <input type="checkbox"/> Cancer | |
| <input type="checkbox"/> Shooting Pain Arms 723.4 | <input type="checkbox"/> Lower Back Pain 724.2 | <input type="checkbox"/> Tuberculosis | |

INSURANCE INFORMATION

NAME OF INSURANCE COMPANY: _____ AUTO: Y / N WORK COMP Y / N

POLICY HOLDER: _____ RELATIONSHIP: _____

DOB for POLICY HOLDER: _____ SSN # for POLICYHOLDER: _____

IN CASE OF EMERGENCY, PLEASE NOTIFY THE FOLLOWING INDIVIDUAL(S)

NAME: _____

RELATIONSHIP TO PATIENT: _____ PHONE # _____

NEAREST RELATIVE NOT LIVING WITH YOU: _____

RELATIONSHIP TO PATIENT: _____ PHONE # _____

PLEASE SIGN BELOW

I hereby authorize payment of medical benefits to Dubin Orthopaedic Centre, P.S.C. for professional services rendered as well as authorizing the release of any information necessary to process this claim. I also grant Dubin Orthopaedic Centre, P.S.C. permission to release copies of my records to my family and/or referring physicians. I understand that for some reason if my insurance company refuses payment for services rendered by Dubin Orthopaedic Centre, P.S.C. , that these will become my responsibility.

Signature of *Patient* or if under 18, Parent or Legal Guardian

Date

Acknowledgment Of Receipt of Notice of Privacy Practices

By signing this form I acknowledge that I have been provided with Dubin Orthopaedic Centre, P.S.C. Notice of Privacy Practices to review and informed that I may keep a copy of reference or obtain a copy upon request.

Date