

Patient Demographics

(Please Fill Out Completely)

CONTACT INFORMATION

Home Phone _____ Work Phone _____ Cell Phone _____

Pharmacy Name and Number _____

May we release confidential information/test results to your partner: Yes / No

May we leave confidential messages on answering machines at: Home: Yes / No Work: Yes / No Cell: Yes / No

PATIENT'S INFORMATION

First Name _____ Middle _____ Last _____

Street _____ City _____ State _____ Zip _____

County: Hamilton Clermont Butler Warren Kenton Boone Campbell Other: _____

Maiden Name _____ Date of Birth _____ SS# _____ Race _____

Name you go by if other than above _____ Marital Status _____

Alternate Contact Name _____ Relationship to Patient _____

Street _____ City _____ State _____ Zip _____ Phone Number _____

Patient's Employer _____ Occupation _____

Street _____ City _____ State _____ Zip _____ Phone Number _____

Employment Status: Full-time Part-time Self-employed Not employed Active Military Retired

Primary Care Physician _____ Referring Physician _____

INSURANCE INFORMATION

Primary Ins. _____ Policy # _____ Group # _____ Eff. Date _____

Street _____ City _____ State _____ Zip _____ Phone Number _____

Secondary Ins. _____ Policy # _____ Group # _____ Eff. Date _____

Name of Policyholder _____ Relationship to patient _____

Patient's Signature _____ Date _____

SPOUSE / PARENT INFORMATION:

First Name _____ Middle _____ Last _____
Street _____ City _____ State _____ Zip _____ Phone Number _____
Name you go by if other than above _____ Date of Birth _____ SS# _____
Marital Status _____ Religion _____ Primary Care Physician _____
Employer _____ Occupation _____
Street _____ City _____ State _____ Zip _____ Phone Number _____
Occupation _____ Status of Employment _____
Spouse's Signature (if infertility visit) _____ **Date** _____

SPOUSE / PARENT INSURANCE INFORMATION:

Primary Ins. _____ Policy # _____ Group # _____ Eff. Date _____
Street _____ City _____ State _____ Zip _____ Phone Number _____
Secondary Ins. _____ Policy # _____ Group # _____ Eff. Date _____
Name of Policyholder _____ Relationship to patient _____