PATIENT HISTORY INFORMATION

(PLEASE PRINT) PLEASE ANSWER ALL QUESTIONS

Name _____ **Birth date** _____ **Age** _____ **SS#** _____

Address _____ **Apt #** _____

City _____ **State** _____ **Zip** _____

Home Phone _____ **Cell Phone** _____ **Work Phone** _____

Office Address _____ **Referred By** _____

Phone number to use for biopsy/lab work results _____ **Can we leave a message?** ◯ Yes ◯ No

Pharmacy Name _____ **Address** _____ **Phone** _____

Sex: ◯ Male ◯ Female **Marital Status:** ◯ Single ◯ Married ◯ Divorced ◯ Widowed

If married – Name of Spouse _____ Spouse Birth date _____ Spouse SS# _____

If patient is under the age of 18.

Name of Mother & Father or legal Guardian _____

Name of responsible party _____ Relationship to Child _____

Address of responsible party _____ SS# _____

In case of emergency: next of kin not living with you

Emergency Contact Name _____ Phone Number _____

Name of Employer _____ Address _____ Phone _____

Name of Spouse or Parent's Employer _____ Address _____ Phone _____

Insurance (Please complete all fields)

Primary	**Secondary**
Insurance Name _____	Insurance Name _____
Subscriber Name _____	Subscriber Name _____
Subscriber Date of Birth _____	Subscriber Date of Birth _____
ID Number _____	ID Number _____
Group Number _____	Group Number _____
Effective Date _____	Effective Date _____
Relationship of patient to Subscriber _____	Relationship of patient to Subscriber _____

Authorization To Pay Insurance Benefits and Release Information To Insurance Company

I hereby authorize my Doctor and/or such assistants as may be selected by him/her to perform such procedures as are necessary and desirable, including but not limited to the services of Pathologist or a laboratory. The authorization granted in the paragraph shall extend to remedying conditions that are not known to my doctor at the time the procedure commences.

I hereby authorize payment directly to William M. Parsley, MD, PSC. I understand I am financially responsible to the above physicians for charges not covered by this authorization.

I authorize Dr. William M Parsley, MD, PSC to release imformation required to complete my insurance claim, and if necessary I authorize my doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

Signature of Patient _____ **Date** _____

(**If minor, signature of parent or legal guardian)

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502-326-2622

FRANKFORT
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Frankfort, KY 40601
502-223-3434

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