ORTHO KENTUCKY, PLLC

Kentucky Bone & Joint Surgeons
230 Fountain Ct, Ste 180
Lexington, KY 40509
859-276-5008

Kentucky Orthopaedic & Hand Surgeons
1780 Nicholasville Rd, Ste 501
Lexington, KY 40503
859-278-3481

Lexington Orthopaedic Associates
2537 Larkin Road
Lexington, KY 40503
859-277-5703

Orthopedic Consultants
1760 Nicholasville Road, Ste 604
Lexington, KY 40503
859-255-9059

Patient Information

Name ______________________________ Birth Date ____________________ Sex __________

Address ______________________________ Social Security # ______________________________

City ________________ State ______ Zip __________ County ________________ Marital Status: __________

Email ______________________________ Race __________ Ethnicity __________ Language __________

Home Phone ______________________________ Work Phone ______________________________

Cell Phone ______________________________ Employer ______________________________

Emergency Contact ______________________________ Employer Address ______________________________

Emergency Phone ______________________________ Are you in or on leave from a skilled nursing facility? __________

Pharmacy ______________________________ Name of facility ______________________________

Referred by Dr.______________________________ Address ____________________ Phone __________

Medical Information

Part of Body / Reason being seen by doctor ______________________________

Medications currently taking ______________________________

Known Allergies to Medications ______________________________

Workers' Compensation/Auto Information

Is your injury work or auto related? __________ Claim filed? ____ Claim # ______________________________

Place of accident/injury ______________________________ Date of Injury ______________________________

Contact Name ______________________________ Phone Number ______________________________

Insurance Information

Policy Holder Information (if other than Patient) Relationship to Patient ______________________________

Policy Holder Name ______________________________ Birth Date ____________________ Sex __________

Billing Address (if different than Patient) ____________________ Social Security Number ______________________________

______________________________ City ____________________ State ______Zip __________

Billing Phone Numbers: Home ____________________ Cell ____________________ Work ____________________

- I give my permission for Ortho Kentucky, PLLC physicians to render treatment to me/my dependent. I understand that I will be given all available pertinent information, prior to treatment being rendered. I understand that I may decline recommended treatment at anytime, but if I choose to do so, it is at my own risk.
- Permission is, hereby, granted to Ortho Kentucky, PLLC physicians to release information to my insurance company, employer, attorney, workers compensation carrier, physician/facility referred to for further treatment, and/or my referring family physician. Permission is here granted to any facility where I have previously been treated to release medical records/x-rays to Ortho Kentucky, PLLC.
- I authorize insurance payment benefits to Ortho Kentucky, PLLC physicians for services rendered. I understand that any charges not paid by my insurance company are my responsibility, and are due and payable by me. This includes but is not limited to co-insurance, co-payments, deductibles, and non-covered services.
- I further acknowledge Ortho Kentucky, PLLC has provided me a copy of its Notice of Privacy Practices, which provides a detailed description of the uses and disclosures allowed by them, as well as other rights I have regarding my protected health information.

______________________________ ____________________

Signature Date