KENTUCKY FERTILITY, GYNECOLOGY AND OBSTETRICS
PRIMARY HEALTH CARE

170 North Eagle Creek DR Suite 101 Lexington KY 40509
Phone 859-277-5736 Fax 859-276-2236

PATIENT INFORMATION

When registering please provide proof of insurance and Picture ID Payment is expected at time of service.

NAME_____

ADDRESS_____

CITY_____ **STATE**_____ **ZIP**_____ **SEX M / F**

HOME PHONE_____**CELL PHONE**_____

DATE OF BIRTH_____ **AGE**_____ **MARITAL STATUS**_____

SOCIAL SECURITY #_____-____- _____ **EMPLOYED Y / N STUDENT Y / N**

EMPLOYER_____ **OCCUPATION**_____

ADDRESS_____ **CITY**_____

STATE_____ **ZIP**_____ **PHONE**_____

SPOUSE / GAURDIAN _____

RELATIONSHIP_____ **PHONE**_____

EMPLOYER_____ **PHONE**_____

PRIMARY CARE PHYSICIAN _____

PHONE_____ **ADDRESS**_____

HOW DID YOU HEAR ABOUT US?_____

PREFFERED PHARMACY _____**PHONE**_____

EMERGENCY CONTACT _____ **PHONE**_____

RELATIONSHIP_____

PRIMARY INSURANCE INFORMATION

COMPANY_____

POLICY HOLDER_____**RELATIONSHIP TO PATIENT**_____

DATE OF BIRTH_____**PHONE**_____**SS#**_____

ADDRESS IF DIFFERENT THAN PATIENT_____

EMPLOYER_____ **PHONE**_____

SECONDARY INSURANCE INFORMATION

COMPANY_____

POLICY HOLDER_____**RELATIONSHIP TO PATIENT**_____

DATE OF BIRTH_____**PHONE**_____**SS#**_____

ADDRESS IF DIFFERENT THAN PATIENT_____

EMPLOYER_____ **PHONE**_____

RESPONSIBLE PARTY IF OTHER THAN PATIENT

NAME_____ **DATE OF BITH** _____

ADDRESS_____

CITY_____ **STATE**_____ **ZIP**_____

PHONE_____ **SS#**_____

EMPLOYER_____ **PHONE**_____

I CERTIFY THAT THE INFORMATION I HAVE PROVIDED IS CORRECT TO THE BEST OF MY KNOWLEDGE. I ALSO UNDERSTAND THAT I AM FINANCIALY RESPONSIBLE FOR ALL CAHRGES WHETHER OR NOT COVERED BY INSURANCE.

SIGNATURE_____ **DATE**_____

Kentucky Fertility, Gynecology and Obstetrics,PLLC

George M. Veloudis, JR, D.O.

Amy L. Claxon PA-C

Name_____Date_____

Age_____Birthdate_____Married_____How long?_____

Religion_____Referred by:_____

Widowed_____Single____Seperated____Divorce____Who do you live with?_____

_____ _____

Last year of school Completed_____Occupation_____

Race_____Ethnicity_____Smoker Y or N How much_____

Alcohol consumption Y or N How much_____ Drug use Y or N Type:_____

Number of Pregnancies and type of delivery _____

_____

Number of miscarriages_____Number of elective abortions_____

Number of Living Children/Ages_____

Last Mammogram Date_____Location_____Last PAP date_____

Abnormal history Y or N Treatment received?_____

Menses regular or irregular_____Post menopausal?_____

Last Menstrual Cycle_____Are you Pregnant?_____

Allergies Y or N Type and reaction_____

List all hospitalizations and surgeries below. (Do not include normal pregnancies)

Month/year Physician Location/Hospital Type of Surgery

_____

_____

_____
_____

List all Medications you are currently taking, dosing and reason for taking:

_____
_____
_____
_____

_____

FAMILY HISTORY:

Mother Age_____Health Problems:_____

Father Age_____Health Problems:_____

Check if you, brothers, sisters, parents, grandparents, aunts or uncles have had the following. Please specify if yourself or which relative it is concerning.

Diabetes-_____

Heart Disease-_____

Epilepsy-_____

High Blood Pressure-_____

Cancer-_____

Multiple Births-_____

Kidney Disease-_____

Mental Illness-_____

Birth Defects-_____

TB-_____

Arthritis-_____

Frequent Headaches-____

Kentucky Obstetrics and Gynecology, PLLC
170 North Eagle Creek Drive, Suite 101 Lexington, KY 40509
Phone(859) 277-5736 Fax(859)276-2236

Consent to Treatment

I/we voluntarily authorize the rendering of such care, including diagnostic procedures and medical treatment, by Dr. George M. Veloudis, Amy L. Claxon PA-C, and/or staff at Kentucky Obstetrics and Gynecology, PLLC, as may in their professional judgment be deemed necessary or beneficial, and may include testing for HIV and drug screening. I/we acknowledge that no guarantees have been made as to the effect of such examination or treatment on my condition or the condition of the person for whom I am duly authorized to sign. I/we understand that I/we have the right to make decisions concerning my health care or the health care of the person for whom I am duly authorized to make such decisions, including the right to refuse medical and surgical procedures.

Release of Information

I authorize the release of information from my medical records or the record of the person for whom I am duly authorized to do so; for the continuum of treatment. Including the following entities, any health, sickness and accident insurance carrier, workman's compensation or agency (social, welfare, governmental) which is legally responsible or which Kentucky Obstetrics and Gynecology, PLLC has good cause to believe is legally responsible for all or any part of the Kentucky Obstetrics and Gynecology, PLLC charges and /or professional fees.

Release of Medical Records

I also authorize the release of my medical records from other physicians, hospitals or health care facilities as it may be needed for my continuum of care or the continuum of care for whom I am duly authorized to sign with Kentucky Obstetrics and Gynecology, PLLC.

_____ _____

Signature of Patient or duly authorized agent Date

_____ _____

Signature of Witness Date

*The above consent may be revoked at any time, except to the extent that action has already been taken, by the patient/duly authorized agent and will expire automatically one year from the date above.

KENTUCKY FERTILITY, GYNECOLOGY AND OBSTETRICS, PRIMARY HEALTH CARE

GEORGE M. VELOUDIS JR. D.O.
AMY CLAXON PA-C

Notice of Privacy Practices for Protected Health Information (HIPAA)
Acknowledgment Form

I have received the notice of privacy practices and have been provided the opportunity to review it.

Patient Name_____Birth date_____
(please print)

Signature_____Date_____