Case# ____________ For Office Use Only

KENTUCKY PHYSICIANS HEALTH FOUNDATION
INITIAL STATISTICAL INFORMATION FORM

PLEASE PRINT CLEARLY

DATE: ____________

Name: ____
(First) (Middle) (Last) (Degree)

Home Address: Street ______________________________

City ____________ State ______ Zip ________

County ____________

Office/Alternate Address:

Street ______________________________

City ____________ State ______ Zip ________

County ____________

Do you want to receive mailings from this office at your home or office? H _____ O _____

Contact Numbers:

Home: ____________ Cell: ____________ Office: ____________

Fax: ____________ Pager: ____________ Other: ____________

Which number would you prefer we use to contact you? ____________

Email Address: ______________________

Date of Birth: ________ SSN: ____________ Race: ____________

Current Medications: ______________________________

____

Last Date of Alcohol Use and Amount: ______________________________

Marital Status: Single _____ Married _____ Divorced _____ Widowed ______

Spouse/Significant Other Full Name: ______________________

Please check any of the following that apply:

Med Student _____ Resident _____ Private Practice _____ Other _____

Current Specialty: ______________ KY License Status ________

I was referred to the Kentucky Physicians Health Foundation by:

Self _____ Work _____ KBML _____ Other ______________________
(please specify)