DEBRA R. BAILEY, MD, FAAP, PSC

2013

Nov-12

419 Town Mountain Road, Suite 202, Pikeville, Kentucky 41501 (606) 437-1511 Fax: (606) 437-1626

Chart #: _			_
Date Entered: _	/_	/20	_

			IATION:		
Patient Name:				Today's Date:	/ /
	(Last)	(First)	(Middle)		
Address:				Home	
				Phone	
		2 112 11 11		_ () Male
Birth Date:	//	Social Security #:		Sex: () Female
School or Day Care:					
		PARENT/GUARDIAN IN	FORMATION:		
Name:				Relation:	
	(Last)	(First)	(M.)	_	
Address:				Home	
if different from				Phone: Work	
if different from patients)				work Phone:	
Social Security		Parent/Guardian's Date		Cell	
		of Birth:		Phone:	
Number:				Other	
				Other Phone:	
Email Address:			oes Parent/Guardian	Phone:	/es no
		D	oes Parent/Guardian	Phone:	/es no
mail Address:		D	oes Parent/Guardian	Phone:	/es no
mail Address:	(Last)	(First)	oes Parent/Guardian	Phone: Smoke? y Relation:	/es no
mail Address:	(Last)			Phone: Smoke? y Relation:	/es no
Employer: Name: Address:	(Last)			Phone: Smoke? S Relation: Home Phone:	/es no
Employer: Name: Address:	(Last)			Phone: Smoke? Smoke Smoke? Smoke	/es no
Employer: Name: Address: (if different from patients)	(Last)			Phone: Smoke? S Relation: Home Phone:	/es no
Employer: Name: Address: (if different from patients)	(Last)	(First)		Phone: Smoke? y Relation: Home	/es no
Email Address: Employer: Name: Address: (if different from patients) Social Security Number:	(Last)	(First) Parent/Guardian's		Phone:	/es no
Email Address: Employer: Name: Address: (if different from patients) Social Security	(Last)	(First) Parent/Guardian's Date of Birth:		Phone:	
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Email Address: Employer: Name: Address: (if different from patients) Social Security Number: Email Address: Employer: 1 2		(First) Parent/Guardian's Date of Birth: DROTHERS & SISTERS	(M.) Poes Parent/Guardian OF PATIENT:	Phone:	/es no Birthday / /

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Name:				
ompany Address:				
ents Relationship t	o Insured: () Self () Spou	use () Child () Other:		
Insured's Sex:	() Male () Female		Insured's Date of Birth:	/
nsured's Name:			Insured's Social Security #:	
sured's Address:	Address: Please present all your inst			
			to the receptionist at every vi	isit. Thank you!
uranaa Campany		SECONDARY INSUR	ANCE INFORMATION:	
surance Company Name:			I. D. #:	
ompany Address:			Group #:	
ents Relationship t	o Insured: () Self () Spor	use () Child () Other:		
Insured's Sex:	() Male () Female		Insured's Date of Birth:	//
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Name:	Child	
Address:	Phone:	
Name:	Relation to Child	
Address:	Phone:	

Parents/Guardians Signature: Date:

_____ Commission Expires:___/__/ Date___/__/

Notary Public, State at Large: _____