Bluegrass Internal Medicine

New Patient Application

Patient Name(First/MI/Last/Suffix): _____

Address:_____ **Date of Birth:** _____

City/State/Zip:_____ **SSN:**_____

Gender: _____ **Cell Phone:** _____ **Home Phone:** _____

Email Address: _____

Alternate Contact Name: _____ **Alternate Contact Phone:**_____

Are you Employed, if Yes – Where? _____

Current Physician: _____ **Reason for Leaving Current Physician:** _____

Primary Insurance	Secondary Insurance
Insurance Name:	Insurance Name:
Insurance Member ID:	Insurance Member ID:
Group#:	Group#:
Policy Holder ID(if different):	Policy Holder ID(if different):
Policy Holder Name:	Policy Holder Name:
Policy Holder Relationship to you:	Policy Holder Relationship to you:
Policy Holder Date of Birth:	Policy Holder Date of Birth:
Medical Claims Address: (Typically a PO BOX)	Medical Claims Address: (Typically a PO BOX)
Eligibility Phone#:	Eligibility Phone#:
Please attach copies of the front and back of cards if possible	

YOUR CURRENT MEDICATIONS:

1.	2.
3.	4.
5.	6.
7.	8.
9.	10.
11.	12.

MAIN HEALTH PROBLEMS:

_____

_____

Have you been referred to this office by a Physician, if so, whom?_____

Return this form by: **Mail/In Person:** Bluegrass Internal Medicine
3346 Professional Park Dr
Owensboro, KY 42303-4551

Fax: 270-713-0227

OFFICE USE ONLY: Accept Patient _____ **Yes** _____ **No** **Signed:**_____
REASON:

BILLING OFFICE USE ONLY: Accept Patient ____ **Yes** ____ **No** **Signed:**_____
REASON/NOTES: