Madison
Family Clinic

2161 Lexington Road
1st Floor, Suite 5
Richmond, KY 40475

Phone: (859) 626-7794
Email: info@madisonfamilyclinic.com

Registration and Health Assessment

This information will be kept confidential.

Date Completed : _____/_____/_____

PATIENT INFORMATION

NAME Last First Middle	Sex ☐ M ☐ F	Date of Birth	Social Security #
Home Address: Street/box City State Zip	Home Phone # ( ) _____ -_____	Cell Phone # ( ) _____ -_____ Work Phone # ( ) _____- _____	

Maiden Name	Place of Birth	Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced
E-Mail Address	**Emergency Contact: Name Phone Relationship**	

Responsible Party's Employer's Name Address City State ZIP	Work Phone

Education: Check highest level completed ☐ Grade School ☐ Jr. High ☐ High School / GED ☐ College ☐ Graduate School

IF CLIENT IS A MINOR, PLEASE COMPLETE THE FOLLOWING. **Is this a foster child?** ☐ Yes ☐ No

(Circle One) Mother's Name / Guardian's Name (1)/Daytime Phone #	Father's Name / Guardian's Name (2)/Daytime Phone #
Person to be contacted about appointments, lab results, etc.	Daytime Phone Number of Contact Person

REFERRING / PERSONAL PROVIDER **Doctor Name:**

Address City State ZIP	Office Phone

Would you like a copy of your report sent to your provider? ☐ Yes ☐ No

INSURANCE INFORMATION ☐ Patient ☐ Parent/Responsible Party Name: SSN: DOB:

Name of Health Insurance	Policy Number / Group Number
Name of Policyholder Policyholder's Date of Birth	Name of Person Responsible for Bill
Policyholder's Address	Employer Name and Phone
Medicare Number	Medicaid Number