



Horizon Healthcare Center
 P.O. Box 23823
 Lexington, KY 40523

Corporate Phone: (859) 278-8772
 Corporate FAX: (859) 276-3565
 After-Hours/Emergency: (859) 278-8771 or 911

Registration and Health Assessment

This information will be kept confidential.

Date Completed : _____ **Location:** _____ **Preferred Provider:** _____

PATIENT INFORMATION

NAME Last First Middle			Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth	Social Security #
Home Phone #			Cell Phone #	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Divorced	
Maiden Name	Place of Birth	Home Address		City	State ZIP
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 <input type="checkbox"/> Grade School <input type="checkbox"/> Jr. High <input type="checkbox"/> High School / GED <input type="checkbox"/> College <input type="checkbox"/> 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 #
--	---

INSURANCE INFORMATION Patient Parent/Responsible Party

Name: _____ SSN: _____ DOB: _____

Please Choose One Of The Following:
 Medicare Medicaid Private Self-Pay

Authorization for Release of Medical Information:

Please list below the individuals with whom we have your permission to discuss the content of your entire medical file. (Please Print)

<u>Name</u>	<u>Relationship</u>	<u>Telephone</u>
1. _____	_____	(____) _____
2. _____	_____	(____) _____
3. _____	_____	(____) _____

I understand that I have the right to revoke this authorization at any time by providing Horizon Healthcare Center, LLC d/b/a Paragon Family Practice with written notification. I also understand that any revocation shall be effective the date it is included in the medical record and will not be retroactive.

Signature: _____ Date: _____