KENTUCKY PHYSICIANS HEALTH FOUNDATION
INITIAL STATISTICAL INFORMATION FORM

DATE: _____

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

Date of Birth: _____ SSN: _____

Home Address: Street _____

City _____ State _____ Zip _____ County _____

Employer Name: _____

Address: _____

City _____ State _____ Zip _____ County _____

Contact Numbers:

Home: _____ Cell: _____ Office: _____

Valid Email Address: _____

Marital Status: Single _____ Married _____ Divorced _____ Widowed _____

Spouse/Significant Other's Full Name: **_____**

Please check: Med Student _____ Resident _____ Fellow _____ Other _____

Current Specialty: _____

Work Status (practicing, not practicing, pending, released): _____

Setting (Agency, Clinic, Private, Hosp., Nursing Home, Educ, Home Health, other):

_____

KY License Status: _____ KY License #: _____

I was referred to the Kentucky Physicians Health Foundation by:

Specific Name of referrer: _____

Organization referrer is with: _____

Address of the referrer: _____

Phone # of referrer: _____

Email Address of referrer: **_____**

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Name: _____

Reason for Referral: _____

_____

Medical Procedures/Surgeries that you have had:

Type: _____ Date: _____

Type: _____ Date: _____

Type: _____ Date: _____

Type: _____ Date: _____

Type: _____ Date: _____

Type: _____ Date: _____

Prior PHP Involvement:

State & Name: _____

Start Date(month/day/year): _____ End Date: (month/day/year) _____

Prior Treatment Experience:

Facility Name: _____

Inpatient or Outpatient: _____ Treatment for: _____

Admission Date(month/day/year): _____ Discharge Date: (month/day/year) _____

Facility Name: _____

Inpatient or Outpatient: _____ Treatment for: _____

Admission Date(month/day/year): _____ Discharge Date(month/day/year): _____

Facility Name: _____

Inpatient or Outpatient: _____ Treatment for: _____

Admission Date(month/day/year): _____ Discharge Date(month/day/year): _____

Facility Name: _____

Inpatient or Outpatient: _____ Treatment for: _____

Admission Date(month/day/year): _____ Discharge Date(month/day/year): _____

Emergency Contact:

Name: _____ Phone Number: _____ Relationship: _____