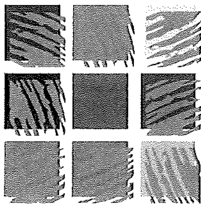

6440 Dutchmans Parkway · Louisville KY 40205-3338
Phone: (502) 896-2606 · Fax: (502) 896-0487
www.squareonemd.com · meds@squareonemd.com

Updated Patient Information

Date: ____________________

Personal Information

Patient's Last Name: _________________________ First: ___________________ Middle: ________

Birth date: ___________ Sex: __M __F Social Security # ____________________________

Child's primary residence

Street: ____

City: _________________________________ State: _________ Zip Code: ____________

Who lives in the home with this child: ____

Available Days and Times:

Home Phone Number(s): (____)________________________ ______________________

Work Phone Number(s): (____)________________________ ______________________

Cell Phone Number(s): (____)________________________ ______________________

(HIPAA CONSENT TO LEAVE MESSAGE)

I do give permission to leave relevant health care information on:

__Home Phone __Work Phone __Cell Phone __E-Mail address: _______________________

Email communications are password secure but not encrypted and may be subject to unauthorized redisclosure or hacking.

Mother's Last Name: _________________________ First: _______________ Middle: _________

Birth date: ______________ Years of Schooling: __________ Occupation: ____________________

Father's Last Name: _________________________ First: _______________ Middle: _________

Birth date: _______________ Years of Schooling: __________ Occupation: ____________________

Parents/Guardians Are: __Biological __Foster __Adoptive __Other: __________________________

(Birth Name of Child, If applicable)

____

Parents' Marital Status

__Unmarried __Married __Domestic Partnership __Single __Separated __Divorced __Widowed

Legal custody Arrangement (select all that apply and attach supporting legal documentation)

__Joint Legal Custody __Joint Physical Custody __Sole Legal Custody __Sole Physical Custody

Non-primary/secondary residential parent information: (please attach legal documentation)

______ **Not Applicable** (please check if patient has no secondary residence)

Relationship to Child: ____

Last Name: _________________________First: ___________________ Middle: __________

Street Address: ____

City: ___________________________ State: _____ Zip Code: __________

Home Number: __________________________ Work Number: ________________________

Cell Number: ________________________ Email/Other: _______________________________