Access Wellness Group, Inc
2401 Regency Road Suite 101
Lexington, KY 40503

Patient Demographic Information

Last Name: _____ First Name: _____ MI _____

DOB: _____ Gender: M F SSN: ___-___-____

Marital Status: Single Married Divorced Legally Separated Widowed

Address: _____

City: _____ State: _____ Zip Code: _____

Cell phone: ( ) _____ May we contact you there? ☐ Yes ☐ No

Home phone: ( ) _____ May we contact you there? ☐ Yes ☐ No

Work Phone: ( ) _____ May we contact you there? ☐ Yes ☐ No

Email Address: _____ May we contact you there? ☐ Yes ☐ No

Emergency Contact Person: _____ Relationship: _____

Emergency Contact Phone: ( ) _____

Primary Care Physician – Name: _____

Preferred Pharmacy: _____

Address/Location: _____

Parent or Legal Guardian Information (if patient is under 16 years of age):

Relationship to Client: _____

Last Name: _____ First Name: _____ MI _____

DOB: _____ Gender: M F SSN: ___-___-____

Address: _____

City: _____ State: _____ Zip Code: _____

Cell phone: ( ) _____ May we contact you there? ☐ Yes ☐ No

Home phone: ( ) _____ May we contact you there? ☐ Yes ☐ No

Work Phone: ( ) _____ May we contact you there? ☐ Yes ☐ No

Email Address: _____ May we contact you there? ☐ Yes ☐ No

Emergency Contact Person: _____ Relationship: _____

Emergency Contact Phone: ( ) _____

How did you hear about *Access Wellness Group*?

___ Insurance ____ Physician ____ Employer ____ Friend

___ Website ____ Newspaper ____ Other: _____

In the future, can we mail a patient satisfaction survey to your home? ☐ Yes ☐ No

May we leave appointment reminder messages at either your cell or home number? ☐ Yes ☐ No

Date completed: _____

Revised 8/2015