HealthCare

- University of Kentucky A.B. Chandler Hospital
- UK HealthCare Good Samaritan Hospital
- UK HealthCare Ambulatory Services
- UK Dental and Oral Health Clinics

SPORTS REHABILITATION NEW PATIENT INSURANCE QUESTIONNAIRE

****Sports Rehabilitation is considered a HOSPITAL BASED SERVICE and will be billed through the UNIVERSITY OF KENTUCKY HOSPITAL****

As an OUTPATIENT HOSPITAL SERVICE and may be subject to your co-pay and/or deductible, and co-insurance.

Name: _____ Work Phone: _____
Address: _____ Home Phone: _____
City/State/Zip: _____ Cell Phone: _____
Social Security #: _____ Date of Birth: _____
Mother's maiden name: _____ Father's first name: _____
Primary language: English or Other: _____
Do you have any religious or other beliefs / customs that may affect how we deliver your care? _____

_____

Spouse/Guardian Name: _____ Spouse/Guardian Date of Birth: _____
Spouse/Guardian Employer, Address & Phone: _____
Spouse/Guardian Title/ Employment Status (full or part time): _____

Your Employer Name and Address: _____
Your Title/Employment Status Full- or Part-time: _____
If Retired please provide date of retirement: _____
Do you presently receive social security? **Yes** ☐ **or** **No** ☐
If receiving social security, are you receiving it due to: **Age** ☐ **Disability** ☐ **List other reason:** _____

Patient's nearest relative:
Name: _____
Address: _____
City/State/Zip: _____
Home Phone: _____ Cell Phone: _____
Relationship to patient: _____

Person to contact in case of emergency:
Name: _____
Address: _____
City/State/Zip: _____
Home Phone: _____ Cell Phone: _____
Relationship to patient: _____

Referring physician and clinic: _____
Have you had surgery regarding this injury or illness? Yes ☐ or No ☐ **If yes,** what surgical procedure did you have?

_____

Is this visit due to an **INJURY** ☐ or **ACCIDENT** ☐ ? If injury or accident, how did this occur? **(Be specific)**

_____

Date & Time: _____ State where occurred: _____ Location: _____
Which part(s) of your body was injured? _____

Is there third party insurance? Yes ☐ or No ☐ . Example of third party insurance is auto, home, school, work)
If yes, please list third party insurance name, address, phone #, and claim #: _____

_____

_____

Do you have health insurance? Yes ☐ or No ☐ **If yes,** please complete information below for the subscriber of your policy
Name of Company: _____
Address: _____
Subscriber's name: _____ Relationship to patient: _____
Subscriber's birth date: _____ Subscriber's social security #: _____
ID #: _____ Group _____
Effective date: _____
Primary care physician (PCP) **[Referral from PCP is mandatory for patients with TRICARE Prime]**
Name of PCP: _____ PCP Telephone number: _____