Joseph R. Leith, M.D.
BELLEFONTE CENTRE
1000 ASHLAND DR., SUITE 103
ASHLAND, KY 41101
606-324-0097

PATIENT INFORMATION – PLEASE PRINT

PATIENT NAME________________________________ SS# ____________________

MARITAL STATUS ☐ S ☐ M ☐ W ☐ D SEX ☐ M ☐ F BIRTHDATE__________ AGE________

MAILING ADDRESS____

HOME PHONE__________________________ CELL/WORK PHONE ________________

EMPLOYER __________________________ OCCUPATION ____________________

EMPLOYER'S ADDRESS____

PRESENT COMPLAINT____________________ HOW LONG?____________________

HAVE YOU BEEN TREATED ELSEWHERE? ☐ Y ☐ N WHOM?____________________

WORK RELATED ☐ Y ☐ N IF YES, INJURY DATE__________ CLAIM #______________

PRIMARY INSURANCE____

SUBSCRIBER NAME______________________ BIRTHDATE______________________

SECONDARY INSURANCE____

SUBSCRIBER NAME______________________ BIRTHDATE______________________

SPOUSE OR PARENT NAME____

MAILING ADDRESS____

FAMILY PHYSICIAN______________________ PHARMACY______________________

DRUG ALLERGIES____

____

DO YOU SMOKE? ☐ Y ☐ N AMOUNT____________ HOW LONG?________________

EMERGENCY CONTACT____________________ NUMBER________________________