

Arthritis and Osteoporosis Center of KY

789 Eastern By-Pass, Suite #17 Richmond, KY 40475

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New Patient Consultation Request

Referring Physician: _____ Date: ____/____/____
Phone# (____) ____-_____
UPIN# _____
NPI# _____ Tax Code# _____

Patient Name: First _____ .M__ Last _____
DOB: ____/____/____. SSN: ____-____-_____
Address: _____ City: _____
State: ____ Zip: _____
Home Phone# (____) ____-_____
Work# (____) ____-_____
Cell#(____) ____-_____

Primary Insurance: _____ Secondary Insurance: _____

Diagnosis/Symptoms: _____

**** Attach the most recent medical records including office notes, labs and x-ray reports. The patient should also bring any related x-ray films with them to their first appointment. ****

We will not be able to move forward with scheduling your patient without this necessary information. If you have not received an appointment date and time within 5-7 business days, please contact us at 859-623-5500.

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