KROHN CLINIC PATIENT INFORMATION **DATE** _____

Patient Name: _____ Medical Record Number: _____
Last First Middle

Date of Birth ____/____/_____ Age: _____ Student: Y N School: _____

Maiden Name and/or Other Previous Last Name(s): _____

Address: _____
Street or Route

_____
City or Town State Zip

Phone # ( )_____-_____ Social Security #_____-_____-_____

Marital Status: Married Divorced Separated Widow/Widower Single

Employer: _____ Phone # ( )_____-_____

Address: _____
Street or Route

_____
City or Town State Zip

Name of Spouse: _____ Birthdate ____/____/_____ SS#_____-_____-_____

If Child (under 18) - ***also complete this section***:

Mother's Name: _____ Birthdate ____/____/_____ SS#_____-_____-_____

Address: _____
Street or Route

_____ Phone # ( )_____-_____
City or Town State Zip

Employer: _____ Employer Phone # ( )_____-_____

Father's Name: _____ Birthdate ____/____/_____ SS#_____-_____-_____

Address: _____
Street or Route

_____ Phone # ( )_____-_____
City or Town State Zip

Employer: _____ Employer Phone # ( )_____-_____

Guarantor (if other than parent): _____ Relation to Patient: _____

Address: _____
Street or Route

_____
City or Town State Zip

Phone # ( )_____-_____ Social Security #_____-_____-_____

Employer: _____ Phone # ( )_____-_____

Name of Person Outside of Residence to Contact in Emergency _____

Address _____

Phone: _____ Relationship: _____

ARE YOU COVERED BY

Medical Assistance	Yes	No	Medicare	Yes	No
Worker's Compensation	Yes	No	Other Insurance	Yes	No

Primary Insurance _____ Phone _____

Address _____

Policy Holder _____ Relationship to Patient _____

Employer _____ Work Phone _____

Address _____

Copayment _____ Deductible: Per Person _____ Family _____

Group Number _____ Subscriber Number _____

Effective date of insurance coverage _____ Subscriber Birthdate _____

List all family members covered under this policy _____

_____

Secondary Insurance _____ Phone _____

Address _____

Policy Holder _____ Relationship to Patient _____

Employer _____ Work Phone _____

Address _____

Copayment _____ Deductible: Per Person _____ Family _____

Group Number _____ Subscriber Number _____

Effective date of insurance coverage _____ Subscriber Birthdate _____

List all family members covered under this policy _____

_____

Worker's Compensation _____ Date of Injury _____
Employer Where Insured

Employer's Address _____

_____ Phone _____

Insurance Company Name _____ Address _____

_____ Claim Number _____

AUTHORIZATION AND ASSIGNMENT:

I hereby authorize Krohn Clinic to furnish the above named insurance companies information (medical/mental health/drug/alcohol) required to process insurance claims. I hereby assign to the Krohn Clinic the sum of money to which I am entitled for medical and/or surgical expenses. This authorization and assignment will be valid until revoked by me. I understand I am financially responsible to Krohn Clinic for any charges not covered by my insurance company.

Signature_____ **Date**_____ **Cancel** _____

Medicare # _____ Effective Date _____

Supplement Insurance ? Y N - if yes, complete Secondary Insurance Section

MEDICARE AUTHORIZATION AND ASSIGNMENT:

I request that payment of authorized medical insurance benefits be made on my behalf to Krohn Clinic Ltd. for any services furnished me by that facility. I authorize any holder of medical information about me to release to Centers for Medicare and Medicaid Services (CMS) and its agents any information needed to determine these benefits or the benefits payable for related services.

Signature_____ **Date**_____ **Cancel** _____

IT IS ENTIRELY YOUR RESPONSIBILITY TO NOTIFY US OF ANY CHANGES OR ADDITIONS IN THE ABOVE INFORMATION. WE ARE NOT RESPONSIBLE FOR WHAT, WHEN OR HOW MEDICAL CARRIER PAYS.