JOHN D. KAUFMAN, M.D., INC.

(Please Print)

PATIENT INFORMATION

Patient's last name: First: Middle:			Married?___ Single?____		To remind you of your appointments please provide Email Address:
Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):		Birth date: / /	Age:	Sex: ❑ M ❑ F
Street address:			Social Security no.:		Home phone no.: ( )
City:		State		Zip Code:	Cell phone no.: ( )
Occupation:		Employer:			Employer phone no.: ( )
Referred by (please check one box): ❑ Yellow Pges		❑ Dr.	❑ Insurance Plan		❑ Family/Friend
❑ Other	❑ Atty	❑ Work Related?	❑ Personal Injury?		❑ Date of Injury

Do we have permission to: Leave a message on your answering machine at home?_____Yes_____No
Detailed info?_____ or Just Phone#?_____
Leave a message at your place of employment?_____Yes_____No
Detailed info?_____ or Just Phone#?_____
Discuss your medical condition with any member of your household?_____Yes_____No
If yes, whom?_____Relationship?_____

INSURANCE INFORMATION

IT IS YOUR RESPONSBILITY TO BE FAMILIAR WITH YOUR INSURANCE POLICY AND COVERAGE. THIS INCLUDES HMO REFERRALS, COPAYS, OUT OF NETWORK, PPO, PLUS PLANS AND DEDUCTIBLES. AS A COURTESY WE WILL BILL YOUR INSURANCE COMPANY, HOWEVER, YOU ARE RESPONSIBLE FOR ALL CHARGES RENDERD TO YOU THAT ARE NOT COVERED BY YOUR INSURANCE COMPANY.

Person responsible for bill:	Birth date: / /	Address (if different):			Home phone no.: ( )
Insurance through work?___		Self?_____			
Occupation:	Employer:	Employer address:			Employer phone no.: ( )
Please indicate primary insurance	❑				
Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	
Name of secondary insurance (if applicable):	Subscriber's name:			Group no.:	Policy no.:
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	

NOTICE OF PRIVACY PRACTICES-ACKNOWLEDGEMENT

Our privacy policy is posted in the waiting room. Copy of the Privacy Practice Policy is available upon request. **By my signature I acknowledge having been offered a copy of the Notice of Privacy Practices.**

_____ _____

Patient/Guardian signature *Date*

IN CASE OF EMERGENCY

Next of kin/friend (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work/Cell phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I also authorize John D. Kaufman, M.D. or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*