PATIENT INFORMATION Date _____

Patient's Name _____ □ □ □ □
Last First Middle Married Single Divorced Widowed

Address _____
Street City State Zip

Birth Date ____/____/____ Age _____ Sex (M/F) _____ Driver's License # _____

Social Security #_____Home Phone ( )_____

Employer _____ Work Phone ( ) _____ Email Address:_____

How were you referred to our office? _____

Who to notify in case of emergency? _____ Day Phone: _____

INSURANCE INFORMATION

Primary Insurance Carrier _____Primary ID #: _____

Name of Insured_____ DOB:_____ Insured S.S.#:_____

Secondary Insurance Carrier _____Secondary ID#: _____

Name of insured_____ DOB: _____ Insured S.S.#:_____

AUTHORIZATION OF MEDICAL BENEFITS

I hereby authorize the _____ Insurance company to pay by check and mail to: Edward M. Kramer, M.D. Inc., 27995 Greenfield Dr., #C Laguna Niguel, CA 92677 The medical and surgical expense benefits allowable and otherwise payable to me under my current insurance policy, as payment toward the total charges for professional services rendered. This payment will not exceed my indebtedness to the above mentioned assigned and **I have agreed to pay any balance of said professional service charges, if any, over and above this insurance payment**. I further authorize the release of any medical information necessary to process this claim.

Signed _____ Date _____

May we leave personal medical information on your answering machine at home? □ Yes □ No

Do you give our office permission to discuss your medical information with family members?

□ Yes □ No If yes, please provide their name and relationship.

Name_____ Relationship_____

Name_____ Relationship_____

I have received a copy of this office's Notice of Privacy Practices (NPP) Pt's Initials_____
I have reviewed a copy of this office's Notice of Privacy Practices (NPP) Pt's Initials_____