Primary Care Partners
Affiliated with Atlantic Health System

Patient Information Form: *Please complete all entries, provide photo ID and Insurance cards*

Isaac Kramer, MD

Mr. Mrs. Ms	**Your Last Name**	**First Name**	M. I.	Date of Birth

Your Preferred Name (NICKNAME)	Your **email**
Street **Address**	**Home** phone number
City, State, Zip Code	**Cell** phone number
Marital Status ○Married ○Single ○Widowed ○Divorced ○Life partner ○Significant other **Employment status:** ○Full time ○Part time ○Retired ○Unemployed ○Disabled ○Student ○Self-employed	Whom may we thank for referring to us
The information below is requested by the government for statistical purposes. If not marked, we will send it as unknown	Your **Pharmacy name** and **phone** number
Your race: ○American Indian or Alaska native ○Asian ○Black or African American ○Native Hawaiian or other Pacific Islander ○White ○Other ○Unknown **Your ethnicity:** ○Hispanic or Latino ○Not Hispanic nor Latino ○Unknown	**Pharmacy location (city)**
Language spoken at home:	Your **MAILORDER** pharmacy
Sex assigned at birth: **Gender Identity:**	**Preferred lab:** ○Labcorp ○Quest ○Other

Emergency Contact Information

Your spouse/friend name **(Last, First)**	Phone number	Nearest friend NOT living with you	Phone number

Insurance information

Primary Insurance plan	ID	Name of the insured (Last, First)	Date of birth of the insured
Secondary Insurance plan	ID	Name of the insured (Last, First)	Date of birth of the insured

Assignment of Benefits/Authorization/Notice of Collection Action

I understand I am responsible for knowing the benefits my insurance plan provides. In doing so, it is also my responsibility to verify proof of insurance by ensuring that the office staff has the most current/valid insurance card on file. I further understand that all co-payments are due at time of service and I am also responsible to pay other amounts due; these amounts may include annual deductibles, charges denied by my insurance company as not covered or not medically necessary, and/or any fees incurred should my account require collection action. (E.G. late fees, collection agency, court or attorney costs). Also, please be advised our office may contact you via an automated system regarding appointments and/or account status. I agree this authorization shall remain valid unless/until I rescind in writing. (Please see the Primary Care Partners Payment Policy and Notice of Privacy Practices for more information)

Signature_____ Print Name_____Date_____

Please complete this section if the patient is covered by Medicare

In order to comply with Medicare regulations, please answer the following questions:

Are you or your spouse employed? ☐ YES ☐ NO Has treatment been authorized by the V.A.? ☐ YES ☐ NO
Do you or your spouse have other insurance? ☐ YES ☐ NO Are you covered under the Black Lung Program? ☐ YES ☐ NO
Are you disabled or have end stage renal disease? ☐ YES ☐ NO Is there Medigap coverage secondary to Medicare? ☐ YES ☐ NO
Is illness/injury the result of an auto accident? ☐ YES ☐ NO Is there insurance coverage primary to Medicare? ☐ YES ☐ NO
Is there employer supplemental coverage secondary to Medicare? ☐ YES ☐ NO

The undersigned certifies that the questions have been answered truthfully and hereby authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services

Signature_____ Print Name_____Date_____