

Patient Information Form

Please Complete all entries

Isaac Kramer, MD

Mr. Mrs. Ms	Your Name (Last, First Middle initial)	Marital Status M S D	Social Security Number	Date of Birth
Street Address		Home phone number		
City, State, Zip Code		Work phone number		
Your employer		Cell phone number	What is the best way to reach you?	
Whom may we thank for referring to us		Your email		

The information below is requested by the government for statistical purposes. If not marked, we will send it as unknown

Pharmacy information

Your race: <input type="radio"/> American Indian or Alaska native <input type="radio"/> Asian <input type="radio"/> Black or African American <input type="radio"/> Native Hawaian or other Pacific Islander <input type="radio"/> White <input type="radio"/> Other <input type="radio"/> Unknown	Your ethnicity: <input type="radio"/> Hispanic or Latino <input type="radio"/> Not Hispanic nor Latino <input type="radio"/> Unknown	Your Pharmacy name and/or phone number
Language spoken at home:		Pharmacy location (city)

Emergency Contact Information

Insurance information

Your spouse/friend name (Last, First)	Phone number	Name of the insured (Last, First)	Date of birth of the insured
Nearest friend NOT living with you	Phone number	Insurance plan	

Consent to disclose Personal Health Information for purposes of treatment, payment.

I understand that **ISAAC KRAMER, MD, P.C.**, its physicians and physician group practices are required to fully document my medical history, current condition, treatment plan and all treatment rendered, including the results of all tests, procedures and therapies. This information is required to be maintained by the organization in a safe and secure way to insure privacy and confidentiality. I understand that the information documented must be available to those involved in my care. Access to my medical record information within the organization is restricted and only available on a Need-to-Know basis. I understand that my health care information, whether stored on paper, computer, film, or other medium is available to ISAAC KRAMER, MD, P.C. physicians and facilities now and in the future on a Need-to-Know basis to health workers involved in my care, teaching, Institutional Review Board approved research, and/or internal utilization management and quality review. I understand that phone calls made to me 24-72 hours prior to the scheduled visit serve as a reminder and would not disclose any clinical information.

I hereby authorize **ISAAC KRAMER, MD** to release my health information requested by any health insurance company related to the claims filed for this visit, or benefit assessment. I also authorize the release of medical information to other hospitals, facilities, physician(s), including referring physician(s), or agencies in order to facilitate my current care following my treatment from **ISAAC KRAMER, MD**, or in the case of medical emergency. All other access is prohibited without my specific written authorization. My signature below constitutes my acknowledgment that I have read and agree with the information provided in this form.

Insurance billing policy

I understand that only my primary insurance carrier will be billed. Any balance left after the primary insurance billing becomes my responsibility.

I agree that if my account is referred to an outside agency or attorney for collection, I will be responsible for an additional *collection fee* of fifty dollars (\$50) or 20% of the balance owed, whichever amount is greater.

Signature: _____ Todays date _____