Kathryn Naus MD PA

Rheumatology

PATIENT INFORMATION

Date ______ ______ ______ Who referred you to us? ____________________

PCP/Internist ____________________

Name ____________________ Birthdate ______ ______ ______ Age ______

Last First Middle

Sex: ◯ Male ◯ Female

Address: ____________________ City ____________ State ______ ZIP ______

Home Phone# ____________________ Work Phone# ____________________ EXT. ______

Social Security # ____________________ Marital Status: ◯ Single ◯ Married ◯ Divorced ◯ Widowed

Employer: ____________________ Address: ____________________

Name of Spouse: ____________________ Spouse SS# ____________________ Birthdate ______ ______ ______

Spouse Employer: ____________________ Address: ____________________

Phone# ____________ Spouse Occupation: ____________ Patients Occupation: ____________

In case of Emergency contact: ____________________ Phone # ____________________

Relationship: ____________________

Reason for office visit ____________________

Primary Insurance: ____________________ Insured SS# ____________ Insured Birthdate ______

Insured name ____________________

Claim Form Address: ____________________ City: ____________ State: ________ ZIP ______

Insured's ID# ____________________ Group# ____________ Phone# ____________

Secondary Insurance: ____________________

Insured's name ____________________

Address: ____________________ City: ____________ State: ________ ZIP ______

Insured's ID # ____________________ Group # ____________ Phone # ____________

I Understand that if any of the insurance information I have provided is incorrect or if I fail to notify the office of any insurance changes that I am responsible for all physician charges and non-covered medical services.

I, hereby authorize the release of any medical information necessary for the processing of insurance. I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled to Kathryn Naus MD PA. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original.

I have received the Notice of Privacy Practices

Patient's signature ____________________