Krabill
FAMILY MEDICINE

1806 Charlton Court
Goshen, Indiana 46526
Phone 574-534-2400
Fax 574-312-6923
www.krabillfamilymedicine.com

PATIENT INFORMATION

Name _____
Last First MI

Address: _____
Street Apt or Lot# City State Zip

Home Phone: ( ) _____ Cell Phone: ( ) _____ Sex: ☐ Male ☐ Female

Birth date: (mmddyyyy)_____ Age: _____ SSN: _____

Employer or School: _____ Phone: ( ) _____

Marital Status: ☐ Single ☐ Married ☐Separated ☐ Divorced Spouse: _____

Emergency Contact Person: _____
(Not living with you)
Phone: ( ) _____ Relationship: _____

RESPONSIBLE PARTY

(If you are under 18 or someone other than you will be responsible for payment of service, please complete the following information.)

Person who will be Paying your Account: _____SSN: _____

Relationship to You: _____Guarantor's DOB (mmddyyyy) _____

INSURANCE INFORMATION

Primary Insurance: _____Owner of Policy: _____SSN _____

Policy Holder's DOB: (mmddyyyy) _____ Relationship to Owner: _____

Secondary Insurance: _____Owner of Policy: _____SSN _____

Policy Holder's DOB: (mmddyyyy) _____ Relationship to Owner: _____

AUTHORIZATION TO REQUEST SERVICE AND TREATMENT FOR MINORS
(Please disregard if the patient is over 18 years of age)

I give my consent to the person(s) listed below to have the right and privilege to request, in my absence, service and treatment for any minor listed above on this form.

Name: _____ Relationship: _____
Name: _____ Relationship: _____
Your signature: _____ Date: _____

AUTHORIZATION

In order for Krabill Family Medicine to provide healthcare to me I understand and authorize the following:

1. Release of information to hospitals, specialists, physicians, or nurse practitioners providing on-call services to Krabill Family Medicine, and to other healthcare providers that may be consulted in the provision of healthcare to me.
2. There may be times when the physicians, nurse practitioners, or members of our staff will need to contact me regarding appointments, test results, or other communications.

Check each box on how we may contact you/who we may speak with. Do not check the boxes that you DO NOT want.

You **can** contact me ☐ on my home phone ☐ on my cell phone ☐ at work
You **can** leave a message ☐ on my home phone ☐ on my cell phone ☐ at work.
☐ I give permission for you to discuss my healthcare with my ☐spouse ☐children☐or others. Please list names of all persons we may discuss your healthcare with.

_____

_____

I understand that should my circumstances change, I am responsible for contacting Krabill Family Medicine and making any changes to these authorizations. I can revoke previous authorization by completing a new authorization form.

_____ _____

Patient's (or Responsible Party) Signature ***Date***