



2240 Karisa Dr., Ste 2
Goshen, Indiana 46526
Phone 574-534-2400
Fax 574-312-6923

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