PATIENT INFORMATION RECORD (PLEASE PRINT OR WRITE LEGIBLY)

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MARIA A. KRONLAGE, D.O.
10735 S. Cicero Ave., Suite 100 • Oak Lawn, IL 60453-5400

WELCOME TO OUR OFFICE

DATE:

PATIENT'S NAME	MARITAL STATUS (S / M / W / DIV / SEP)	DATE OF BIRTH	SOCIAL SECURITY NO.

STREET ADDRESS ☐ PERMANENT ☐ TEMPORARY	CITY AND STATE	ZIP CODE	HOME PHONE NO.

PATIENT'S EMPLOYER	OCCUPATION (INDICATE IF STUDENT)	HOW LONG EMPLOYED?	BUSINESS PHONE NO.

EMPLOYER'S STREET ADDRESS	CITY AND STATE	ZIP CODE

IN CASE OF EMERGENCY CONTACT	PHONE

WHO REFERRED YOU TO THIS PRACTICE?

PRIMARY CARE PHYSICIAN	PHONE

IF THE PATIENT IS A MINOR OR STUDENT

MOTHER'S NAME	STREET ADDRESS, CITY, STATE AND ZIP CODE	HOME PHONE NO.

MOTHER'S EMPLOYER	OCCUPATION	HOW LONG EMPLOYED?	BUSINESS PHONE NO.

EMPLOYER'S STREET ADDRESS	CITY AND STATE	ZIP CODE

FATHER'S NAME	STREET ADDRESS, CITY, STATE AND ZIP CODE	HOME PHONE NO.

FATHER'S EMPLOYER	OCCUPATION	HOW LONG EMPLOYED?	BUSINESS PHONE NO.

EMPLOYER'S STREET ADDRESS	CITY AND STATE	ZIP CODE

ALL PROFESSIONAL SERVICES ARE CHARGED TO THE PATIENT. NECESSARY FORMS WILL BE COMPLETED TO HELP EXPEDITE INSURANCE CARRIER PAYMENTS. HOWEVER, THE PATIENT IS RESPONSIBLE FOR ALL FEES, REGARDLESS OF INSURANCE COVERAGE. IT IS ALSO CUSTOMARY TO PAY FOR SERVICES WHEN RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE WITH OUR OFFICE BOOKKEEPER.

INSURANCE AUTHORIZATION AND ASSIGNMENT

Name of Policy Holder_____ Policy Holder DOB_____

I request that payment of authorized Medicare/Other Insurance company benefits be made either to me or on my behalf to_____ for any services furnished me by the party who accepts assignment/physician. Regulations pertaining to Medicare assignment of benefits apply.

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim/other Insurance Company claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment. (Section 1128B of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding this information).

Signature _____ Date_____