

Kimball M. Crofts, M.D.

Patient Information



Patient Introduction										
Patient Name: Last			First			M.I.		Todays Date		
Address					City		State	Zip		
Age	Sex	Birthdate		Status	<input type="checkbox"/> Married	<input type="checkbox"/> Widowed	HomePhone			
				<input type="checkbox"/> Single	<input type="checkbox"/> Divorced	<input type="checkbox"/> Separated				
Social Security #		E Mail			I would like email reminders of future appointments		<input type="checkbox"/> Yes	<input type="checkbox"/> No	Work Phone	
ReferredBy					Mobile Phone		I would like text reminders of future appointments		<input type="checkbox"/> Yes	<input type="checkbox"/> No

Reason for Visit		
If Accident: How?	When?	Where?

Responsible Party			
Name		Relationship to Patient	Home Phone
Home Address		City	State
Social Security #	Employer		Business Phone

Primary Insurance Information			
Insurance Co.	Policyholder	Patient Relationship to Insured	
		Self	Spouse
		Child	Other
Insurance Co. Address		Birthday of Policyholder	Insurance Phone
Social Security # or ID #	Group #	Workers Comp Claim#	

Secondary Insurance Information			
Insurance Co.	Policyholder	Patient Relationship to Insured	
		Self	Spouse
		Child	Other
Insurance Co. Address		Birthday of Policyholder	Insurance Phone
Social Security # or ID #	Group #	Self	Spouse
		Child	Other

Authorizations	
<p>I hereby authorize release of information for insurance claim purposes.</p> <p>BENEFITS TO PHYSICIAN: I hereby authorize insurance payments directly to the physician of the surgical and or medical benefits. I also understand I am responsible for any portion of my bill not covered by my insurance company and I agree to pay interest at a rate of 1 1/2% per month (18% annum) on an unpaid balance over 30 days old. I agree to pay all lawful collection costs, including court and attorneys fees should my account be turned over for collection. I understand the office will preauthorize my surgery as a courtesy. I have been notified that preauthorization is not guarantee of payment and accept responsibility of any unpaid amount. I am encouraged to call my insurance company and verify prior authorization and benefits of my procedure. I understand it is my responsibility to obtain a referral to Dr.Crofts if it is required by my insurance policy.</p> <p>I also understand that photographs may be taken in the management of my case.</p> <p>I understand all the above and hereby state that the information is correct to the best of my knowledge. My signature indicates that I have read the above and grant the request of the authorization and also agree to honor billing policies as outlined in the treatment, payment and health care operation consent.</p>	
Signed: _____	Date: _____