Dr. Stephen Krzeminski

Patient Information

Pharmacy:____________________________

Today's Date:____________________________ Primary Doctor:____

Patient's Name: First Name___________________________MI_________Last Name________________________________

Address:____________________________________City______________________State________Zip_____________

Home Phone(_____)_____-_______Work Phone: (_____)_____-________ Ext______ Cell Phone(____)_____-_________

SS#_____________________Marital Status: S M D W Sex:____Female ___Male DOB:____/____/_____ Age:_____

Employer:____ Occupation:____________________________________

Address:____City:___________________State:__________ Zip_______

If Applicable: Spouse's Name:________________________________ SS#:________-_____-________

DOB:____/____/_______ Employer:___________________________ Work Phone:__________________

Complete If Patient Is Under 18 Years Of Age

Father's Name:___________________________________ Employer:____

Work Phone:_____________________________________ DOB:___/___/_____

SS#:________________________

Mother's Name:__________________________________ Employer:____

Work Phone:_____________________________________ DOB:___/___/_____

SS#:________________________

In Case Of An Emergency Contact (Not Living With Patient)

Name:____ Phone:____

Relationship to Patient:__________________________ Other #:_______________________________________

Insurance Information

Primary Insurance

Policy Holder Name:________________________________

Insurance Company:________________________________

Policy Holder SS#:_________________________________

Policy Holder DOB:_________________________________

Policy Holder Employer:_____________________________

Secondary Insurance

Policy Holder Name:______________________________

Insurance Company:______________________________

Policy Holder SS#:_______________________________

Policy Holder DOB:_______________________________

Policy Holder Employer:___________________________

I authorize treatment of the above patient.
I authorize the release of medical records necessary to process insurance claims.
I am responsible to pay for all services received, regardless of insurance coverage.
I authorize payment of medical benefits to be made directly to Lakeshore ENT, P.A., Dr. Stephen Krzeminski.
I authorize the release of correspondence and/or medical records to other medical providers involved in the patient's care.
I have read and understand the Financial Policy.

Signature:____________________________________Relationship:______________________Date:________________

Please See Other Side