

# Gigi Kroll, MD ♦ Zhanna M. Pinkus, MD

## PATIENT ACCOUNT INFORMATION

### PATIENT

Patient Full Legal Name \_\_\_\_\_  
Address \_\_\_\_\_ Last \_\_\_\_\_ City \_\_\_\_\_ First \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ M.I. \_\_\_\_\_  
Home Phone \_\_\_\_\_ Business Phone \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Marital Status:  Single  Married  Divorced  Widowed  Domestic Partner Physician \_\_\_\_\_  
Employer Name \_\_\_\_\_ Social Security # \_\_\_\_\_  
Employer Address \_\_\_\_\_ Email \_\_\_\_\_  
Where do you prefer to receive calls?  Home  Work  Cell  OK to leave message

### RESPONSIBLE PARTY

Check here if same as patient and skip to insurance information:   
Name \_\_\_\_\_  
Last \_\_\_\_\_ First \_\_\_\_\_ M.I. \_\_\_\_\_  
Address \_\_\_\_\_

### PRIMARY INSURANCE INFORMATION

Insurance Company Name \_\_\_\_\_ PPO  Private   
Insurance Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Name of Insured \_\_\_\_\_  Male  Female  
Insured Date of Birth \_\_\_\_\_ Insurance I.D. # \_\_\_\_\_ Group # \_\_\_\_\_  
Insured Employer Name \_\_\_\_\_  
Relationship to Patient:  Self  Spouse  Child  Other \_\_\_\_\_

### SECONDARY INSURANCE INFORMATION

Insurance Company Name \_\_\_\_\_ PPO  Private   
Insurance Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Name of Insured \_\_\_\_\_  Male  Female  
Insured Date of Birth \_\_\_\_\_ Insurance I.D. # \_\_\_\_\_ Group # \_\_\_\_\_  
Insured Employer Name \_\_\_\_\_  
Relationship to Patient:  Self  Spouse  Child  Other \_\_\_\_\_

### EMERGENCY CONTACT INFORMATION

Name of Person to Contact \_\_\_\_\_ PPO  Private   
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

I hereby assign my insurance benefits to be made directly to my physician and any assisting physicians for services rendered. I hereby attest that the above insurance information accurate and that I am an eligible member and understand that I am responsible for knowing my benefits/coverage. I will be financially responsible for all charges that are not covered by my insurance company. I also hereby authorize the release of all information to other physicians and insurance carriers upon request for the purpose of payment for medical services and further treatment of care by another physician. I further agree that a photocopy of this agreement shall be as valid as the original. Payment is due at the time services are rendered. All charges are the direct responsibility of the patient. I understand that services cannot be rendered on the assumption that charges will be paid by the Insurance Company and that insurance is an agreement between me and my insurance company. If there are problems collecting payment, attorneys fees, collection agency costs and any related fees will be added to the bill. I hereby acknowledge that I have read, understand and agree to hereby give consent to access, treat and test.

Patient's Signature: \_\_\_\_\_ Date \_\_\_\_\_