KNEPPER CONCIERGE MEDICINE
ELEVATING HEALTHCARE, ONE PATIENT AT A TIME

PATIENT INFORMATION FORM

This information will be placed in your confidential medical record and will be used exclusively by **Knepper Concierge Medicine** to facilitate your care.

PLEASE PRINT -- THANK YOU!

_____ _____ _____
Last Name **First Name** **M.I.**

_____ _____
Address **City, State, Zip**

_____ _____
Date of Birth **Name of Spouse/Partner (Full Name)**

_____
Names of Dependent Child(ren) Member(s)

_____ _____
Primary Phone # Please circle: Home Work Cell **Secondary Phone # Please circle: Home Work Cell**

_____ _____ _____
Patient E-mail Address **Pharmacy Name** **Pharmacy Phone #**

Please indicate your preferred contact phone # (circle one): **Home Work Cell**

May we leave a detailed message at your preferred phone #? **Yes No**

In addition to yourself, to whom may we release your medical information?

Please list name (s) and their relationship to you: _____

_____

_____ **I prefer that you address any issues related to my medical care only with me.**

Do you check your email on a regular basis? **Yes No**

Do you use and are you comfortable communicating via text messaging? **Yes No**

EMERGENCY INFORMATION:

Please indicate an emergency contact with who we may share necessary information regarding you with this person:

_____ _____ _____
Last Name **First Name** **Relationship**

_____ _____
Home Phone # **Other Phone #**

(continued on back)

PHYSICIANS/SPECIALISTS SEEN IN LAST 12 MONTHS:

Name of Previous Primary Care Physician (PCP)	**Contact Information**
Names of Specialist Caring for You (1)	**Contact Information**
Names of Specialist Caring for You (2)	**Contact Information**
Names of Specialist Caring for You (3)	**Contact Information**
Names of Specialists Caring for You (4)	**Contact Information**

INSURANCE INFORMATION:

Primary Insurance Carrier | **Date of Birth** | **ID or Policy Number** | **Group/Code**

Subscriber's Name and Relationship to Patient | **Subscriber's SSN** | **Effective Date**

Secondary Insurance Carrier (if applicable) | **Date of Birth** | **ID or Policy Number** | **Group/Code**

Subscriber's Name and Relationship to Patient | **Subscriber's SSN** | **Effective Date**

Employer Name | **Occupation**

Do you currently have a worker's compensation claim open? **Yes** **No**

If yes, what is the injured body part? _____

PATIENT AUTHORIZATION:

I hereby authorize **Knepper Concierge Medicine** to release any information acquired in the course of my examination or treatment necessary to process insurance claims. I assign any benefits payable by my insurance carrier to the provider services submitting a bill for services rendered. I further authorize the release of any necessary information, including medical for any related claim to the above insurance company. I accept financial responsibility for any collection/attorney fees the physician incurs in collecting payments for which I am responsible. A copy of this agreement may be used in place of the original. This authorization may be revoked at any time in writing. I certify that all the above information stated on this form is true and accurate.

_____/_____/_____

Signature of Patient or Patient/Legal Guardian **Printed Name** **Date**