PATIENT INFORMATION FORM

This information will be placed in your confidential medical record and will be used exclusively by **Northern Michigan Rheumatology (NMR) and Irene S. Kazmers, MD** to facilitate your care.

PLEASE PRINT -- THANK YOU!

_____ _____ _____ _____
Last Name **First Name** **M.I.** **Nickname (if preferred)**

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

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

_____ _____
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 provide an emergency contact who may help us reach you if needed, and with whom we may communicate your medical information if necessary.

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

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

(Continued on back)

NAME OF CURRENT PRIMARY CARE PHYSICIAN (PCP):

Name	**Degree (MD, DO, PA, FNP, NP or other)**
Address	**City/State**
Fax Number	**Phone Number**

INSURANCE INFORMATION: (Please note, NMR does not accept Medicaid in any form as primary or secondary insurance and does not participate in Workers' Compensation cases).

Primary Insurance Carrier	**ID or Policy Number**	**Group/Code**
Subscriber's Name and Relationship to Patient	**Subscriber's Date of Birth**	**Effective Date**
Secondary Insurance Carrier (if applicable)	**ID or Policy Number**	**Group/Code**
Subscriber's Name and Relationship to Patient	**Subscriber's Date of Birth**	**Effective Date**

Employer Name

PATIENT AUTHORIZATION:

I hereby authorize **Northern Michigan Rheumatology and Irene S. Kazmers, MD** 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 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**