KERRY L. KUHN, MD, LLC

New/Update PATIENT FORM

(please print clearly)

PT NAME: _____ DATE: _____

SS # _____

STREET: _____

APT # _____

CITY _____ ST _____ ZIP _____

TEL# _____ CELL# _____

DOB ____/____/____ Lang. Spoken _____

Marital Status S ( ) M ( ) W ( ) D ( )

POLICY HOLDER _____

STREET: _____

APT # _____

CITY _____ ST _____ ZIP _____

TEL# _____

Relationship _____

Referred by: _____

E-mail Address _____

Pharmacy Name _____ Tel. # _____

EMPLOYER

_____

Address _____

Phone: _____

SPOUSE: _____

EMPLOYER: _____

Address _____

Phone: _____

IN CASE OF EMERGENCY PLEASE NOTIFY:

_____ PHONE: _____

NEAREST FRIEND OR RELATIVE NOT LIVING WITH YOU:

_____ PHONE: _____

MEDICAL INSURANCE:

PRIMARY _____

INSURED: _____

ID# _____

GROUP# _____

MEDICARE # _____

SECONDARY _____

INSURED: _____

ID# _____

GROUP# _____

ASSIGNMENT OF BENEFITS, TO FACILITATE PROCESSING OF ANY INSURANCE CLAIMS

a. I hereby assign all medical and or surgical benefits to which I am entitled, including Medicare, private insurance and any other health play to Kerry L. Kuhn, MD, LLC.

b. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignor to release all information necessary to secure the payment.

c Payments MUST be made at the time of each visit, UNLESS PRIOR PAYMENT ARRANGEMENTS HAVE BEEN MADE. A surcharge of 35% will be added to any accounts sent to our collection department.

I HAVE READ AND UNDERSTAND THE ABOVE:

Signed by: _____ DATE:: _____

How would you like to be contacted by us?

Patient's rights of disclosures: In general, the HIPAA privacy rule gives the individuals the right to request restriction on uses and disclosures of health information. The individual is also provided the right to request confidential communications of health information be made by alternative means.

I, _____, wish to be contacted in the following manner:

HOME
_____ Ok to leave a detailed message
_____ Leave message with callback number only

CELL PHONE
_____ Ok to leave a detailed message
_____ Leave message with callback number only

WORK
_____ Ok to leave a detailed message
_____ Leave message with callback number only

Written communication
_____ OK to mail to home
_____ OK to fax to home _____ fax number
_____ OK to fax to work _____ fax number

List all persons in your household who, in your absence, may make requests on your behalf, and with whom we may speak regarding your medical information.

NAME RELATIONSHIP

_____
_____
_____
_____

Patient Signature:_____ Date:_____

KERRY L. KUHN, MD, LLC

Kerry L. Kuhn, M.D. Donna Hamilton, CNM, MSN

(954) 755-1300 • FAX (954) 755-7799

REQUEST FOR RELEASE OF MEDICAL RECORDS

To: _____
Physician or Hospital Name

_____
Address

_____
City State Zip Code

I Hereby authorize that my medical records be released to:

KERRY L. KUHN, MD, LLC
1725 N. University Drive
Suite 440
Coral Springs, FL 33071

Please include the following information:

- ☐ Operative Report
- ☐ Discharge Summary
- ☐ Pathology Reports
- ☐ Labor & Delivery, Prenatal Records
- ☐ Office Records

_____ _____ _____
Patient's Name (print) DOB Telephone #

_____
E-mail Address

_____
Patients' name at time of procedure / Date of Procedure

_____ / _____ _____
Patient's Signature Witness Date

_____ _____
Signature of employee releasing records Date