LAKESHORE

EAR • NOSE • THROAT • SINUS • ALLERGY • FACIAL PLASTIC SURGERY

Dr. Stephen Krzeminski

Patient Information

Pharmacy: _____

Today's Date: _____ Primary Doctor: _____

Patient's Name: First Name _____ MI _____Last Name _____

Address: _____City _____State _____Zip _____

Primary Phone (_____)_____-_____ Alternate Phone (_____)_____-_____Work Phone (_____)_____-_____

SS# _____ Marital Status: S M D W Sex: ____ Female ____ Male DOB: ____/____/_____ Age: _____

Employer: _____Occupation: _____ Retired: Y N

Address: _____City: _____ State: _____ Zip: _____

Email Address: _____

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

Name: _____ Phone: _____

Relationship to Patient: _____ Alt Phone: _____

Insurance Information

Primary Insurance

Policy Holder Name: _____

Insurance Company: _____

Policy Holder SS #: _____

Policy Holder DOB: _____/_____/_____

Policy Holder Employer: _____

Relationship to Patient: _____

Secondary Insurance

Policy Holder Name: _____

Insurance Company: _____

Policy Holder SS #: _____

Policy Holder DOB: _____/_____/_____

Policy Holder Employer: _____

Relationship to Patient: _____

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.

Patient/Resp Party Signature: _____Relationship:_____Date:_____

Please See Other Side