EDMUND KRASINSKI, JR., D.O., F.A.C.G., P.L.L.C.

PATIENT INFORMATION

Please print all information, legibly, in the spaces provided

Legal Name: _____Date of Birth: _____/_____/_____

Address: _____

City: _____State: _____Zip:_____

Phone: _____ Cell Phone: _____

Email Address: _____

Referring Doctor/Primary Care Doctor: _____

Preferred Method of Communication: ☐ Email ☐ Home Phone ☐ Mobile Phone ☐ Work Phone

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline to answer

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American

☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Decline to Answer

Sex: ☐ Male ☐ Female SS#_____

Employer: _____ Work Phone: _____

Emergency Contact:_____

Relationship: _____ Phone: _____

Our practice utilizes the web based EHR (Electronic Health Record) system, Practice Fusion. This system allows us to share your PHR (personal health records) from our practice with you via the patient portal, Patient Fusion. If you would like our practice to initiate this service for you (email address is required) please check here:

☐ Yes, please initiate a link via Patient Fusion and your practice

☐ No thank you.

Please continue to page two

Page two of Patient Information

LAST NAME	***FIRST NAME***	***D.O.B.***	***TODAY'S DATE***

INSURANCE INFORMATION

PRIMARY INSURANCE:

Company Name: _____

Name of Insured : _____

Insured's DOB: ____ / ____ / ____ Relationship to patient: _____

Member ID Number: _____ Group Number:_____

SECONDARY INSURANCE:

Company Name: _____

Name of Insured : _____

Insured's DOB: ____ / ____ / ____ Relationship to patient: _____

Member ID Number: _____ Group Number: _____

AUTHORIZATION BY PATIENT

I authorize the release of medical information, to and from Edmund Krasinski, Jr., D.O., for medical, insurance or legal purposes.
I authorize transmission of information on my behalf electronically.
I authorize payment of medical benefits to Edmund Krasinski, Jr., D.O.
Patients are responsible to understand their insurance coverage. You are required to know which hospitals and laboratories are covered under your plan.
I agree to pay for all fees that are not covered by my insurance company.

Signature:

_____

Date:

_____

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