Kristine Eule, MD Confidential Patient Profile Date:

Patient Last Name	First Name:	Middle:
Birthdate:	Social Security#	
Race/Ethnicity (circle) Asian Black White Hispanic Other_____	Marital Status (circle) Single Married Divorced Widowed	
Address:	City/State	Zip
What is your primary phone number (circle) Home Work Cell	E-Mail	
Home Phone	Work Phone	Cell Phone

Emergency Contact Information

Name:	Phone	Relationship (circle) Spouse Parent Other

GUARANTOR INFORMATION – Complete this section if patient is a minor or someone else is responsible for the bills

Guarantor Last Name:	Guarantor First Name:
Address:	
Phone Number:	Relationship to Patient:

PRIMARY INSURANCE INFORMATION

Insurance Name:	**Insurance Phone #:**
Primary Policy Holder:	Relationship to Patient:
Primary Policy Holder's Birthdate:	Employer (for group policies)
Member ID:	**Group #**
Claims Address:	

SECONDARY INSURANCE INFORMATION

Insurance Name:	**Insurance Phone #:**
Primary Policy Holder:	Relationship to Patient:
Primary Policy Holder's Birthdate:	Employer (for group policies)
Member ID:	**Group #**
Claims Address:	

PREFERRED PHARMACY INFORMATION

PHARMACY NAME	Phone
ADDRESS	CITY/STATE/ZIP

Authorization to file insurance claims and Financial Responsibilities:

I hereby authorize payment of insurance benefits to Kristine Eule, MD and any assisting physicians for services rendered. I understand that I am financially responsible for payments of any charges that are not covered by my insurance company; including co-payments, deductibles, co-insurance and any service denied as non-covered or denials for any other reason by the insurance company. In the event of default, I will be held responsible for payment of all collection costs and an associated attorney fees.

Use of Protected Health Information (PHI)

I understand that my protected health information will be shared for the purpose of treatment, payment and any health care related operations. By my signature below, I authorized the release of my protected health information. I agree that a photocopy of my signature shall be as valid as the original.

Laboratory and Pathology Services

Laboratory and/or Pathology services are not rendered in our office; blood and/or tissue specimens will be sent to the laboratory or pathologist for evaluation and reporting. These services will be billed by the individual laboratory and/or pathologist and are NOT included in our fees. You may receive a separate bill from the laboratory and/or pathology company. I understand that I may be financially responsible for payment of such services in addition to the services rendered by Kristine Eule, MD.

PATIENT (OR RESPONSIBLE PARTY) SIGNATURE:	**DATE:**