Karen E. Kennedy, M. D.
PATIENT INFORMATION

Date:_____ Primary Care Physician: _____

Patient's First, MI, Last Name | Date of Birth

Address | City, State, Zip

Home Telephone | Work Telephone | Cellular Telephone

Social Security No. | Marital Status/Circle (S M D W) | Student/Circle (FT PT)

Employment: ___FT ___PT ___Self ___Not Employed ___Retired

Employment | Address

Email Address | Referred By

Reason for Visit

Insurance Information: **Subscriber** *(person who is cardholder of the insurance policy)*
_____Check here if patient is subscriber.
(If not, he/she is my relationship) Child Parent Spouse Significant Other Guardian

Name First, MI, Last | Date of Birth | Social Security No.

Street Address | City, State, Zip

Home Telephone | Work Telephone | Cellular Telephone

Employment Company Name | Occupation

Insurance Carrier | Begin Effective Date | End Effective Date

Certification/Policy No. | Group No | Group Name

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Secondary Insurance Information: **Subscriber** *(person who is cardholder of the insurance policy)*_____Check here if patient is subscriber.
(If not, he/she is my relationship) Child Parent Spouse Significant Other Guardian

Name First, MI, Last	Date of Birth	Social Security No.
Street Address	City, State, Zip	
Home Telephone	Work Telephone	Cellular Telephone
Employment Company Name	Occupation	
Insurance Carrier	Begin Effective Date	End Effective Date
Certification/Policy No.	Group No.	Group Name

Statement of Financial Responsibility, General Release of Protected Health Information

I acknowledge that I am responsible for all charges for services provided to me by the office of Karen E. Kennedy, M.D., P.A., including any amount not paid by my insurance plan or health maintenance organization (HMO's). I understand this includes collection fees and attorney fees of these balances.

Florida law stipulates that any person who knowingly and with intent to injure, defraud or deceive any insurance company files a statement of claim containing any false, incomplete or misleading information is guilty of a felony of the third degree.

I authorize Karen E. Kennedy, M.D., P.A. to release any and all my Protected Health Information to all my insurance carriers, other third-party payers and their utilization review agencies, federal and state agencies, employers who are self-insured health insurance payers or their fiscal intermediaries, for continued care and treatment, or for other insurance purposes.

Signature Date

In case of emergency, please contact: _____
Name/Relationship

Telephone No. Home Work Cellular