Dr. Kathryn Amacher, DO

PATIENT INFORMATION/ REGISTRATION: Print Legibly and complete in its entirety

Patient Information:

Patient Name: _____D.O.B_____

Facility Address:_____Room #:_____

City: _____ Zip Code:_____ **Gender:** ☐ Female ☐ Male

Marital Status: ☐ single ☐ married ☐ widowed ☐ divorced

Does the patient have decision making capacity to handle medical and financial decisions: ☐ yes ☐ no

Emergency Contact/DPOA: (Please provide copy of POA)

Power of attorney/Emergency Contact Name:_____

Relationship: _____ Phone: _____

Billing Address: _____

Email: _____Secondary Phone: _____

Secondary Emergency Contacts

1. _____
2. _____
3. _____

Billing Information:

BILLING INFORMATION, send copy of insurance cards to avoid being billed

Primary Insurance: _____ ID Number: _____

Social Security Number: _____

Secondary Insurance: _____ **ID Number:** _____

Billing Contact (if different than above):

Name: _____**Phone:** _____

Address: _____

<u>Medical Information:</u>

Prior Primary Care Provider: _____

Preferred Pharmacy: _____

Current Specialists:

1. _____
2. _____
3. _____

Are any specialists' referrals needed: ☐ **yes** ☐ **no**

What referrals are needed? _____

Does patient manage their own medication? ☐ **Yes** ☐ **No**

Surgical History:

1. _____
2. _____
3. _____

Does Patient smoke: ☐ **yes** ☐ **No** ☐ **former smoker quit** _____

Does Patient drink: ☐ **yes** ☐ **No** ☐ **former drinker, quit** _____

Does Patient do illicit drugs? ☐ **Yes** ☐ **No** ☐ **Former drug use, quit_____**

Patient E-Chart:

We utilize an electronic chart for communication and records sharing, in the space provided below please let us know where we can send patient portal access. The chart we use is called Ethizo and all chart updates come from Ethizo email address.

Primary Patient Portal Access:

Name: _____ Cell Phone:_____

Email: _____

Consents:

I consent to a photograph for identification purposes _____ (Initials)

I have read the tele-health policy and agree to tele-health _____ (Initials)

I have read and agree to the Privacy Policy _____ (Initials)

Authorization and Assignment: I hereby authorize my insurance carrier, attorney or any third party payer to pay directly to Kathryn Amacher, DO all charges submitted for service incurred by me. I understand I will be responsible for all charges not paid by my insurance company. I authorize Kathryn Amacher, DO to release information concerning my medical condition to my insurance, hospital, physicians or attorney for the purpose of processing claim. I assign payment directly to Kathryn Amacher, DO which may be due from Medicare program or any other insurance company, including supplemental insurance, which may cover in whole or in part medical services which I have received. The authorization and assignment shall be valid until I notify Kathryn Amacher, DO in writing the cancellation. A photocopy of authorization shall be as valid as the original copy.

Patient/or DPOA Signature: _____ Date: _____