**MARC KRESS MD & ASSOCIATES Today’s Date:**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Prefix Miss Mr. Mrs. Ms. Mx. Other: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Preferred Name: | | | | | | | | | | | | | |  | | | | | | | | | | |
| **Patient’s Name** | | | | | | | | | |  | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | |  | | | | | | | | | | |
|  | | | | | | | | | | First | | | | | | | | | | | | | | | | | | | Middle | | | | | | | | | | | | | | Last | | | | | | | | | | |
| Address | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | |  |
|  | | | | | Street & Apt # | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | City | | | | | | | | | | | State | | | | | Zip |
| SS# | | |  | | | | | | | | | | | | | | | Birthdate | | | |  | | | | | | | | | | | | Age: | | | | |  | | Sex assigned at birth: | | | | | | | ❑ Female ❑Male ❑Prefer not to say | | | | | |
| Current Gender Identity: ❑ Female ❑ Male ❑ Transgender Male ❑ Transgender Female ❑ Genderqueer ❑ Other | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Relationship Status | | | | | | | | | | ❑ Single | | | | | | ❑ Married to: | | | | | | |  | | | | | | | | | | | | | | ❑Separated | | | | | ❑ Divorced | | | | | ❑ Widowed | | | | ❑ Other | |
| Home Phone | | | | | |  | | | | | | | | | | | | | | | | Cell Phone | | | | |  | | | | | | | | | | | | | | | | Other Phone | | | | |  | | | | |
| Preferred Contact: | | | | | | | | | | | | ❑Home ❑ Work ❑Cell | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | |  | | | | | | | | | | |
| Any restrictions for contacting you? | | | | | | | | | | | | | | | | | | | | | | | | ❑No ❑ Yes | | | | | | | | | If yes, please describe | | | | | | | | | | | | | |  | | | | | |
| Can we leave routine test results message for you at your preferred phone contact? ❑ Yes ❑ No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Work Phone | | | | | | | |  | | | | | | | | | | | | | | | | | Ext: | |  | | | | | | | Is it okay to call you at work? | | | | | | | | | | | | | | ❑ Yes ❑ No | | | | |
| Emergency Contact: | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | Relationship to Patient: | | | | | | | | | | | | | | | | | | | Phone#: | | |  | | |
| Patient’s Employer | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | Occupation | | | | | | | | | | | | | |  | | | | | | | | | | |
| **Ethnicity:** | | | | **❑Hispanic ❑Non-Hispanic** | | | | | | | | | | | | | | | | | | | | | | | | | **Language:** | | | | | | | | | | |  | | | | | | | | | | | | | |
| **Race: ❑African-American ❑Asian ❑ American Indian/Native Alaskan ❑Native Hawaiian or Other Pacific Islander ❑White** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| How did you hear about us? | | | | | | | | | | | | | | | | | | | ❑ Friend ❑ Insurance ❑ Internet ❑ Other | | | | | | | | | | | | | | | | | | | | | | | | Details: | | | | | | | | | | |
| Referring Dr.: | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | |  | | | | | | | | | | | |
| **INSURANCE INFORMATION** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Primary Ins. | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | ID # | | |  | | | | | | | | | | | Group # | | |  | | | | | |
| Insured: Name | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | DOB | | | | | |  | | | | | | | | | | | SS# |  | | | | | |
| Relationship to the insured? | | | | | | | | | | | | | | | | | | | | ❑Self | | | | | | ❑Child | | | | | | ❑Spouse | | | | | | | | ❑Other | | | |  | | | | | | | | |
| Secondary Ins. | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | ID # | |  | | | | | | | | | | | | | | Group # | |  | | | |
| Insured: Name | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | DOB | | | | | |  | | | | | | | | | | | SS# |  | | | | | |
| Relationship to the insured? | | | | | | | | | | | | | | | | | | | | ❑Self | | | | | | ❑Child | | | | | | ❑Spouse | | | | | | | | ❑Other | | | |  | | | | | | | | |
| **OTHER DOCTORS TREATING YOU** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Name/Specialty** | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | **Phone/Address** | | | | | | | | | | | | | | | |  | | | | | | | | |
| PRIVACY PRACTICES NOTICE & WRITTEN ACKNOWLEDGEMENT FORM  *I have been offered a copy of* ***Marc Kress MD & Assoc.*** *Notice of Privacy Practices.* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Signature of Patient/Guardian: | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | Date: | |  | | | | | |
| AUTHORIZATION OF PAYMENT & RELEASE OF INFORMATION  *I request payment of authorized insurance benefits be paid to* ***Marc Kress MD & Assoc.*** *and authorize release of medical information as needed to determine payable benefits for services rendered. I understand that I am financially responsible for all charges whether or not covered by insurance.* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Signature of Patient/Guardian: | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | Date: | |  | | | | | |

Would you like to share your email with us? (We don’t communicate with patients that way now, but may in the future.)

Email