**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