Elizabeth Etkin-Kramer, M.D., F.A.C.O.G.

New Patient Information and Consents:

Name: ____ Today's Date: _________________________

Social Security # ______________________________________ Date of Birth: __________________________

Home Address: ____ Home Phone: ___________________________

City: __________________ State: ___________ Zip: __________ Cell Phone: ___________________________

Occupation: ______________________ □ full time student Work Phone: ____________________________

Employer/School: ________________________________ **Email address**: ____

Work/school address: _________________________________City: _______________ State: __________ Zip: ___________

Marital status: □ Married □ Single □ Divorced □ Widowed □ Domestic Partnership Sign Other's Name: ________________

Spouses Employer (if applicable): ____________________________ Address: _________________________________

City: ____________________ State: __________ Zip: __________ Telephone: __________________________

Emergency Contact Information:

Name: _______________________________ Relationship: ______________ Telephone number: _____________________

Please list family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment and health care operations).

Name: _______________________________ Relationship: _____________ Telephone number: ______________________

Insurance Information

Insurance Plan: _____________________ **ID#** ___________________________________ **Group#** _____________________

Referral and Pharmacy Information

Primary Care Physician: ____ Telephone number: ______________________

Preferred Pharmacy and location: __________________________________ Telephone number: ______________________

Acknowledgement of receipt of privacy notice: (HIPPA): By initialing this and signing below, you acknowledge that the office of Elizabeth Etkin-Kramer, MD, LLC has offered or given you a copy of its Privacy Notice, which explains how your health information will be handled. We must attempt to have you sign this form on your first date of service with us after April 14, 2003. This includes the situation where your first date of service occurred electronically. If your first date of service with us was due to an emergency we must attempt to give you this notice and get your signature acknowledgment receipt of this notice as soon as possible after the emergency. _________ Initials

Policy regarding liability insurance: Under Florida Law, physicians are generally required to carry medical malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice. **YOUR DOCTOR HAS DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE.** This is permitted under Florida Law. Subject to certain conditions Florida law imposes penalties against noninsured physicians who fail to satisfy adverse judgements arising from claims of medical malpractice. This notice is provided pursuant to Florida law. My initials and signing below indicate awareness of this policy. _______ Initials

Authorization: I, the undersigned certify that I (or my dependent) has insurance coverage as listed above and assign directly to Elizabeth Etkin-Kramer, MD, LLC. I understand that I am financially responsible for all charges whether or not paid by insurance. I remain responsible for payment of co-pays, deductibles, non-covered services, and any other charges not paid by insurance within 30 days. I hereby authorize Elizabeth Etkin-Kramer, MD, LLC to release all information necessary to secure payment of benefits. I authorize the use of this signature for all insurance claims.

SIGNATURE: ____ **DATE**: ____________________________