PATIENT INFORMATION Today's Date_____

_____ _____
Last Name First Name
Middle Initial

_____
Address

_____
City State Zip

(_____)_____ (____)_____
Phone Cell

_____
Email **for internal use only*

Marital Status (S) (M) (D) (W) Age _____

_____ _____
Date of Birth Social Security Number

_____ _____
Spouse's Name Primary Phone

GUARANTOR INFORMATION

Responsible Party_____ Relationship _____

Social Security No. _____ DOB _____

Emergency Contact (other than spouse) _____

_____ _____
Phone Relationship

_____ _____

Name of nearest relative not living with you Relationship

_____ _____

Address Phone

_____

Name of Banking Institution

_____ _____

Address Phone

EMPLOYER INFORMATION

_____

Name of Patient/Guardian's Employer

_____

Address

_____

City State Zip

(_____)_____ _____

Phone Your Occupation

REASON FOR VISIT

Reason for Visit: ____Illness _____Auto Accident _____Injury _____Cosmetic

Please explain:

REFERRAL INFORMATION

How were you referred to our office? _____

Name of person who referred you: _____

MEDICAL HISTORY

Are you allergic to any medication(s)? _____

Do you smoke? ___Yes ___No Pack(s) per day _____

Please check if you have any of the following medical conditions:

_____diabetes	_____ hypertension	_____ heart disease
_____asthma	_____ lung disease	_____ cancer
_____HIV/AIDS	_____ seizures	_____ kidney disease
_____immunosuppressive disorder		_____ bleeding disorder

Please list any other illnesses:

_____

_____

Please list any previous surgeries (including cosmetic) with corresponding dates:

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Please list all current medication (including vitamins):

_____

_____

_____

Primary Physician: _____

Dentist: _____

SIGNED AUTHORIZATION

I hereby authorize the office of Peter F. Kunz, M.D. to release any medical information required in the course of my examination and treatment. I also consent to have my photographs taken by an employee of Dr. Kunz and permit their use for medical records and, if advantageous in the judgment of my

physician, for medical education and/or medical lectures. In addition, I hereby authorize the use of my photographs for the MIAS website.

Signature _____ Date _____
(Patient or Parent/Legal Guardian)

I recognize and accept responsibility for services rendered regardless of insurance coverage. This includes but is not limited to co-insurance, co-payment, and deductible and non-covered services. I authorize payment directly to Peter F. Kunz, M.D., and do hereby assign all insurance proceeds or benefits payable by virtue of services rendered by Peter F. Kunz, M.D. and authorize Dr. Kunz to advise my insurance carrier of such assignment.

I authorize payment to be made directly to Dr. Kunz from my insurance carrier to the extent of the services performed and agree that if it becomes necessary to file suit to recover any uncollected charges, I will be responsible for reasonable attorney fees, court costs, late fees and expenses for collections.

Signature _____ Date _____
(Patient or Parent/Legal Guardian)

Witness _____ Date _____