Alfred Peters, M.D
Kristin Kroeker, M.D
Confidential Patient Information Sheet

MRN _____

Please print clearly in black ink

Patient _____
Last **First** **MI**

Home Address _____
City **State** **Zip code**

Married / Single / Widowed / Divorced / Seperated / Other _____

Date of Birth ____/____/____ **Age** _____ **Social Security #** ____-____-____
(Your social security is necessary for insurance purposes)

Primary Phone# _____ Home Cell Work Secondary Phone # _____ Home Cell Work

Email _____ Driver's License # _____

Employed By _____ Work Phone # (____) _____

Occupation _____

Pharmacy of choice _____ Location _____ Phone (____) _____

Primary Care Physician _____ Referred by _____

INSURANCE INFORMATION: Please provide a current copy of your insurance card.
****If insurance is through **spouse or parent**, you must provide **complete** information below ****

Primary Ins Carrier _____ **member** Self/ Spouse/ Parent **through** Individual or Employer

Secondary Ins Carrier _____ **member** Self/ Spouse/Parent **through** Individual or Employer

Name of Spouse (or Parent/Insured): (circle one)

_____ DOB____/____/____ SSN#____-____-____

Employed By _____ Cell Phone # _____

Occupation _____ Work Phone# _____

In case of an emergency, who should be notified (**other than the above name**)?

Name: _____ Primary Phone# (____) _____

Relationship: _____ Secondary Phone# (____) _____

I authorize Dr. Peters & Kroeker's office to discuss medical and billing information related to my care with the following family members/individuals.

Name: _____ Relationship _____ Phone # _____

Name: _____ Relationship _____ Phone # _____

May we leave personal medical and billing information on your answering machine at home or cell phone? YES NO

_____	_____	_____	____/____/____
Patient or Person authorized to consent	Print name if other than patient	Relationship to patient	Today's Date