Karim HealthCare

Affordability - Availability - Quality

605 West Chicago Street, Suite 2, Coldwater, Michigan 49036 3271 West Carleton Road, Hillsdale, Michigan 49242 122 South Main Street, Reading, Michigan 49274 600 South Lakeview Avenue, Suite 103, Sturgis, Michigan 49091 112 South Chicago Street, Litchfield, Michigan 49252 18297 N US 127, Cement City, Michigan 49233 (517)924-1444 (P) (517)924-1445 (F) (517)437-3879 (P) (517)437-4053 (F) (517)797-4547 (P) (517)797-4543 (F) (269)832-8911 (P) (517)437-4053 (F) (517)797-4547 (P) (517)797-4548 (F) (517)547-4845 (P) (517)547-4583 (F)

Pati	ent Demographic Form		·			· · · · · · · · · · · · · · · · · · ·	
	Last Name:	First Name:	Patient Information	Date of	Birth:	Previous Name (if applicable):	
	Mailing Address:						
	City/State/Zip:						
2	Home Phone: Cell Phone: Work Phone:						
Patient Information	Ok to leave a detailed message		Ok to leave a detailed message		Ok to leave a detailed message		
	Preferred Method of Contact for reminder calls an Only One Option) Voice Message	1		Can we leave a message regarding your medical care and test results?			
	Email Address:		Prim		Primary Care Physician:	rimary Care Physician:	
	Sex:	Employer Name/Address					
	Marital Status:		Spouse/Significant Other – Name and Birthdate:				
Additional Information	Race (please select): White American Indian or Alaska Native Asian Other Decline to Specify Hispanic Black or African American Native Hawaiian or Pacific Islander Preferred Language (please select one): Ethnicity (please select one): Hispanic Other Other Other						
	Unknown Decline to Specify Emergency Contact Information Please do not leave blank. Emergency Contact (NOT living with you): Relationship to Patient:						
	Address:			Phone:			
	City:	State:		Zip:			
	Primary Medical Insurance Secondary Medical Insurance						
	Ins. Company Name:		Insurance Company Name				
	Policy Holder:	Date of Birth:	Policy Holder:			Date of Birth:	
ë ë	ID/Policy Number: Group No	ımber:	ID/Policy Number:			Group Number:	
Insurance Information	Patient Relationship to Policy Holder:		Patient Relationship to Policy Holder:				
	Responsible Party – If the patient is a minor (under the age of 18), the parent or guardian						
_ =	Last Name: First Name: First Name:						
	Date of Birth:	Sirth:		Phone:			

I have read and agree to Karim HealthCare's payment policy. I understand that payment is my responsibility regardless of insurance coverage. I hereby assign to Karim HealthCare all money to which I am entitled for medical expenses related to services performe from time to time by Karim HealthCare, but not to exceed my indebtedness to Karim HealthCare. I authorize Karim HealthCare to release any medical information to my insurance carrier or third party payer to facilitate processing my insurance claims, understand that failure to pay outstanding balances within 90 days of notification of the amount due will result in submission to an outside collection agency. By choosing text messaging and/or email as a communication method, I acknowledge Karim HealthCare is not liable for any wireless charges I may incur and encrypted patient information may be sent to me via text message or email.

MEDICARE REPREFICIARIES: I request that payment of authorized Medicare benefits her pages to CASE as a local section of the page to the control of the page to the control of the page to th

State:

Relationship to Patient:

Zip:

MEDICARE BENEFICIARIES: I request that payment of authorized Medicare benefits be made to Karim HealthCare. I authorize any holder of medical information about me to release to CMS and its agents any information needed to determine these benefits the benefits payable for related services.

Signature of Responsible Party	Date:

Address of Person Responsible

City: