Patient Information Form Date:

THE KAUFMANN CLINIC, INC.

Thank you for choosing the Kaufmann Clinic. Please completely fill out this form to ensure the fastest and best healthcare service. We may ask you to look over this information from time to time to make sure it stays up-to-date. Please have your insurance card and picture I.D. ready to photo copy.

Patient Name	Social Security Number
Date of Birth	Address
Sex ☐ Male ☐ Female Marital Status ☐ Single ☐ Married ☐ Widowed	City, State, Zip
Home Phone	Work Phone
Mobile phone or pager	Email Address
Employer	Occupation
Insurance company name and policy number/Primary (see your insurance card) __________ __________ Effective Date __________	Insurance company name and policy number/Primary (see your insurance card) __________ __________ Effective Date __________
Emergency Contact Name/Relationship	Phone

If you are covered under the policy of a spouse, partner, parent, or legal guardian, please tell us about them:

Patient Name	Social Security Number
Date of Birth	Address, City, State, Zip
Home Phone	Work Phone
Mobile phone or pager	Email Address
Employer	Occupation