**Florence Kimbo M.D., LLC**
Medical Arts Building 1
18660 Bagley Road, Suite 404
Middleburg Hts., Ohio 44130
Ph: (440) 234-8746

**Patient #**

**Last Name** _____ **First Name** _____ **Middle Initial** _____

**Social Security Number** _____ **Date of Birth** _____

Address _____ City, State, Zip Code _____

Phone # Home _____ Cell# _____ Work # _____

**(Reminder calls for appointments are offered as a courtesy but are not guaranteed.)**

Gender M / F Marital Status Single / Married / Div / Sep / Widowed Student Status Full time / Part time / Not a student

Name and Address of Employer:_____

PHARMACY INFORMATION: Name: _____City: _____Ph:_____

**EMERGENCY CONTACT**

Emergency Contact Name _____ Relationship _____ Phone # _____

**I authorize "FKMD" to contact the above named person in case of emergency and to disclose the name of my doctor if necessary**

► **INITIALS** _____

**GUARANTOR (FINANCIALLY RESPONSIBLE PARTY) INFORMATION**

**You cannot financially obligate anyone other than yourself for these services if they are not present to sign this form.**

**If you wish to name someone other than yourself as GUARANTOR, they must be present to sign this form.**

**If patient is a minor the guarantor is the parent/guardian that brings the patient to their appointments and must sign form.**

***Check Here if Same as Patient (and Sign Below)*** _____

Last Name _____ First Name _____

Relationship to Patient _____ Social Security # _____ Date of Birth _____

Address _____ City, State, Zip Co_____

Phone # Home _____ Cell _____ _____

Employer Name and Address _____

► **GUARANTOR SIGNATURE** _____ **DATE** _____

**OVER PLEASE →**

**I understand that by not providing correct insurance information below, I may be responsible for the payment of fees not covered by my insurance. ► GUARANTOR INITIALS _____**

**PRIMARY INSURANCE INFORMATION**

Name of Insurance _____ Effective Date _____

ID # _____ Group # _____

Phone #_____ Address for Claims_____

Is pre-authorization required for your insurance? _____ Authorization#_____

Do you have other / secondary insurance? _____ If so enter information below.

**PRIMARY INSURANCE POLICY HOLDER INFORMATION** ***Check Here if Same as Guarantor _____***

Last Name _____ First Name_____

Date of Birth _____ Relationship to Patient _____

Address _____ City, State, Zip Code_____

Employer Name and Address _____

Phone # Home _____ Cell _____ Work_____

**SECONDARY INSURANCE INFORMATION**

Name of Insurance _____ Effective Date _____

ID # _____ Group # _____

Phone #_____ Address_____

**SECONDARY INSURANCE POLICY HOLDER INFORMATION** ***Check Here if Same as Guarantor _____***

Last Name _____ First Name _____ Middle Initial ____

Date of Birth _____ Relationship to Patient _____

Address _____ City, State, Zip Code_____

Employer Name and Address _____

Phone # Home _____ Cell _____ Work_____ _

**I certify that the information provided on both sides of this intake form is true and accurate to the best of my knowledge**

**► SIGNATURE _____ DATE_____**