VICTOR P. KRESTOW, M.D., P.A.
NORLAND MEDICAL CENTER
SEVEN N.W. 183rd STREET
MIAMI, FLORIDA 33169-4574
(305) 652-3614

Patient Information

Date _____

Patient Name | *Last, First, Middle Initial* _____

Email Address _____

Address | *Street Number* _____

City, State and Zip Code _____

Home Phone _____ Mobile _____ Work _____

Date of Birth _____ Social Security Number _____

Marital Status *(circle one):* Single | Married | Widowed | Separated | Divorced Gender *(circle one):* Male | Female

Employer | *If student, list name of school* _____

Referring Physician _____ Primary Physician _____

Federal law requires Race, Ethnicity and Language for collections
If you prefer not to report, you may choose Refuse to report. Please check one per category that applies.

Race: *(check one)*

- ☐ Asian
- ☐ American Indian or Alaska Native
- ☐ Black/African American
- ☐ Middle Eastern
- ☐ Native American
- ☐ Other Pacific Islander/Native Hawaiian
- ☐ White/European
- ☐ More than one race
- ☐ Refuse to report
- ☐ Undefined
- ☐ Other _____

Ethnicity: *(check one)*

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Refuse to report

Preferred Language: *(check one)*

- ☐ English
- ☐ Spanish
- ☐ Other _____

Responsible Party | *If Patient is under 18 years of age this section must be completed.*

Name _____ Date of Birth _____

Relationship to patient _____

Home Phone _____ Mobile _____ Work _____

Address | *Street Number* _____

City, State and Zip Code _____ Social Security Number _____

Emergency Contact _____ Relationship _____

Home Phone _____ Mobile _____ Work _____

Primary Insurance _____ Group # _____

Policyholder Name _____ Relation to Patient _____

Member ID# _____

Social Security Number _____ Police Holder Date of Birth _____

Secondary Insurance _____ Group # _____

Policyholder Name _____ Relation to Patient _____

Member ID# _____

Social Security Number _____ Police Holder Date of Birth _____

☐ Self Pay discount information requested

How did you hear about us? *Please check all that apply:*

☐ Physician _____ ☐ Website _____ ☐ Mailer _____

☐ Family Member/Friend ☐ Billboard _____ ☐ Radio _____

☐ TV/Cable _____ ☐ Newspaper _____ ☐ Workers Comp

☐ Seminar/Special Event _____ ☐ Yellow Pages/Phone Book/ Online Yellow Pages

I certify all the above information is true and correct.

_____

Patient Signature or Responsible party Date