Florence Kimbo M.D., LLC
Medical Arts Building I
18660 Bagley Road, Suite 404
Middleburg Hts., Ohio 4413
Ph: (440) 239-8746 Fax: (440) 234-8748
www.florencekimbomd.org

Patient #

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

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

Address _____ **City** _____

State _____**Zip Code** _____

Phone Home# _____ **Cell#** _____ **Email:** _____

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

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 Please use **"NA"** in the fields that are not applicable

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_____