the office of TATYANA KUTSY, M.D. 425-637-2340

CONFIDENTIAL PATIENT INFORMATION

Patient's Name:_____
(last) *(first)* *(m.i.)*

Street Address_____

City_____ State_____ Zip_____

Phone _____ _____
(home) *(work)*

Soc. Sec. # _____ SEX _____ Birth Date_____ Age_____

RESPONSIBLE PARTY/PARENT INFORMATION (if patient is a minor)

Last Name_____ First_____ M.I.____ Phone#_____

Social Security:_____ Date of Birth_____

Employer:_____ Job Title:_____ How Long_____

Address:_____ City:_____ Zip:_____

Insurance Information

(Please present proof of insurance at time of service.)

Name of Coverage_____

Subscriber's
Name_____ I.D.#:_____

If co-pay or deductible is due, how much?_____ Group #:_____

Name & phone number of friend or relative not living with you:

Patient Consent & Responsibility for Payment *(please read carefully)*

The undersigned consents to and authorizes treatment by Dr. Kutsy and her immediate assistants. The undersigned grants Dr. Kutsy's office the right to release any or all medically pertinent information about the patient upon demand by the party paying the patient's account. The undersigned agrees that, notwithstanding any insurance, government program, or third-party suit, which may pertain to the patient's account, he/she is ultimately responsible for full payment of all treatments and procedures performed or authorized by Dr. Kutsy's office.

_____ _____
(signature) *(date)*

(note: parent or guardian must sign if patient is underage or incapacitated)

We would appreciate it if you would provide the following information as well: How did you find out about Dr. Kutsy?