

TROY FAMILY PRACTICE, P.L.L.C.
STACEY BELTZ, D.O. NORAH DUNCAN, M.D. KATHRINE KRANZ, PA-C ANN FORDE, NP-C

Legal Name: _____, _____, _____ Sex: M/F
Last First Middle Initial

Address: _____

City: _____ State: _____ Zip: _____

Primary Phone #: _____ Alternate Phone: _____

Social Security #: XXX-XX-_____ Birth Date: _____

Are you: Married Single Divorced Widowed Primary Language: _____

Race: _____ Ethnic Background: Hispanic/Latino or Not Hispanic/Latino

E-mail Address: _____

Legal Guardian/Parent (If parent is minor) or Spouse: _____

In case of emergency, contact: _____

Relationship: _____ Phone #: _____

Employer: _____

Do you have an Advanced Directive or Living Will? Yes / No

How did you hear about our office: Family Member Friend Co-worker Newspaper ad Web Site
Other _____

IN ACCORDANCE WITH HIPPA REGULATIONS, IR YOU WOULD LIKE THIS OFFICE TO
RELEASE/DISCUSS YOUR MEDICAL INFORMATION WITH SOMEONE OTHER THAN YOURSELF,
PLEASE COMPLETE THE FOLLOWING:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Signature: _____ Date: _____

I AUTHORIZE THE DOCTOR TO BILL MY INSURANCE CARRIER AND IF NECESSARY TO RELEASE ANY
MEDICAL OR PERSONAL INFORMATION REQUIRED TO PROCESS THE INSURANCE CLAIM ON MY
BEHALF.

Signature: _____ Date: _____

Primary Insurance: _____ Policy Holder: _____ Birth Date _____
Subscriber Subscriber