KATHY KRAUS, R.D., CD-N

CT LICENSE NUMBER: 000222
CELL: 203-912-9449
OFFICE: 203-324-4033

1458 BEDFORD STREET
STAMFORD, CT 06905
EMAIL: kehkraus@aol.com

PATIENT REGISTRATION INFORMATION

Name: _____ Date: _____
Address: _____
Email: _____ Date of Birth: _____
Daytime Phone: _____ Cell Phone: _____
Work Phone: _____ Social Security No: _____
Occupation: _____ Employer: _____
Employer Address:_____

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship to Patient: _____
Address: _____
Phone: Home_____ Cell: _____Work: _____

PRIMARY CARE PHYSICIAN

Name: _____ Phone Number: _____
Address:_____

REFERRAL

Do you have a referral from your doctor? (if yes, complete line below)
Authorization number: _____
Number of visits authorized: _____

HOW WERE YOU REFERRED TO MY SERVICES?
Physician Friend Relative Insurance Company Other

HEALTH INSURANCE INFORMATION

Primary Insurance: _____ Phone: _____
Insurance ID Number: _____ Group Number:_____
Policy Holder: _____ Date of Birth: _____
Policy Holder's Address: _____
Relationship to patient: Self Parent Spouse Other
Co-pay amount: $ _____ Effective Date:_____

I, the undersigned certify that I (or my dependent) have insurance coverage as stated above and assign directly to Kathy Kraus, RD, CD-N all my insurance benefits payable by said carrier(s).

I understand that Kathy Kraus, RD, CD-N, will submit to my insurance carrier(s) for the services rendered today. I understand that I am responsible for obtaining any referrals required prior to the services being rendered. I further understand that I am financially responsible for all charges paid or not paid by insurance and I am also responsible for payment of any services deemed “not covered” under the terms of my benefit contract.

I hereby authorize Kathy Kraus, RD, CD-N to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Patient Signature: _____ Date: _____

If the patient is a minor or otherwise incapacitated (physically or mentally), complete the following.

Signature of Person of Authority: _____
Relationship to Patient: _____