Kanarek
ALLERGY - ASTHMA - IMMUNOLOGY
4601 W 109th Street, Ste 350 Overland Park, KS 66211
p: 913-451-8555 http://kallergy.com f: 913-327-8553

Last Name _____Middle Initial _____ First Name _____

Address _____ City _____ State _____ Zip Code_____

Home Phone (___)_____-_____Work Phone (___)_____-_____ext_____Cell Phone (___) _____-_____

SS#_____-_____-_____ Date of Birth _____/_____/_____ Sex ☐ F ☐ M E-Mail _____

Emergency Contact _____Relationship _____ Phone (___) _____-_____

Address/City/State _____

Referring Physician or
Primary Care Physician _____ Phone Number (_____) _____-_____

ALLERGIC TO MEDICATION _____

Responsible Party _____ Relationship_____ Phone (___) _____-_____

Address/City/State (if different from above) _____

Insurance Information- (Name and Mailing Address)

Primary _____ Secondary_____

Policy #_____Group#_____ Policy #_____Group#_____

Insured's Name _____ Date of Birth __/__/____/____ Sex ☐ F ☐ M

Social Security Number _____/_____/_____ Relationship to Patient _____

Employer _____ Employer's Address _____

Work Phone Number (_____) _____-_____ City_____State_____ Zip Code_____

I HAVE BEEN OFFERED AND/OR RECEIVED A COPY OF THE HIPAA PRIVACY PRACTICES AND POLICIES OF HENRY J KANAREK, MD, PA

INITIAL_____ DATE_____

Information (including messages) about my appointments and/or health information may be communicated by:

☐ Home Phone ☐ Work Phone ☐ Cell Phone ☐ Email ☐ Text Message

HIPAA (Protected Health Information) Designees:

Designee Name _____ Phone (_____) _____-_____ Relationship_____

☐ All Info ☐ Appointment Info ☐ Financial Info ☐ Medical Info

Designee Name _____ Phone (_____) _____-_____ Relationship_____

☐ All Info ☐ Appointment Info ☐ Financial Info ☐ Medical Info

Designee Name _____ Phone (_____) _____-_____ Relationship_____

☐ All Info ☐ Appointment Info ☐ Financial Info ☐ Medical Info

THIS FORM MUST BE COMPLETED IN FULL AND MUST BE SIGNED. PAYMENT IS REQUIRED AT TIME OF SERVICE unless previous payment arrangements have been made. I hereby authorize Henry J. Kanarek, MD, PA to release information concerning any illness, treatment or hospital stay to my insurance company. I hereby assign to the doctor all payments for medical services rendered to my dependents or me. This assignment will remain in effect until revoked by me in writing. A photocopy of any assignment is to be considered as valid as the original. I understand that I am responsible for all charges whether or not paid by insurance. I hereby authorize said assignee to release all information to secure payment.

Signature _____ **Date** _____/_____/_____