Kennebec Medical Consultants

13 Railroad Square Suite 2
Waterville, ME 04901

PATIENT INFORMATION FORM

Please Print

Patient Name (First, Last and Middle Initial): ____

Sex: ☐ M ☐ F Age: ____ Date of Birth: _____/_____/_____ Social Security #: ______-_____-______

Marital Status: ☐ Married ☐ Divorced ☐ Widowed ☐ Single ☐ Minor

Address: ____________________________________ City: _______________ State: ____ Zip Code: ________

Home Phone #: (____)_____-_______ Work #: (____)_____-______ Ext: _____ Cell #: (____)_____-_______

Email Address:
____@____

☐ Employed ☐ Unemployed ☐ Retired ☐ Disabled ☐ Military

Employer/Business Name: ____ Occupation: ________________

Emergency Contact Name: ____ Phone #: (____)_____-________

Emergency Contact Relationship: ☐ Mother ☐ Father ☐ Spouse ☐ Other ___________________________

Primary Physician's Name: ____ Did they refer you? ☐ Yes ☐ No

If no, please indicate who referred you: ____

Primary Insurance: __________________________ Policy ID #: _______________ Group #: _______________

How much is your deductible? ________ How much have you used? ________ Max Annual Benefit: ________

If Patient is NOT the Primary Card Holder: Name of Insured: ____

Relationship to Patient: ____________________ Date of Birth: ___________ Social Security #: ____________

Secondary Insurance: ________________________ Policy ID #: _______________ Group #: _______________

How much is your deductible? ________ How much have you used? ________ Max Annual Benefit: ________

Name of Insured: _______________________ Relationship to Patient: ____________ Date of Birth: _________

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Patient Signature (Parent or Guardian if Patient is a Minor) Date