HARRY B. KRAM, M.D., F.A.C.S., F.C.C.M.

VASCULAR, ENDOVASCULAR AND GENERAL SURGERY

☐ **TORRANCE**
3445 PACIFIC COAST HWY.
SUITE 230
TORRANCE, CA 90505-6660
OFFICE: (310) 326-3800
FAX: (310) 326-3870

☐ **DOWNTOWN L.A.**
1400 S. GRAND AVE.
SUITE 815
LOS ANGELES, CA 90015-3048
OFFICE: (213) 749-5347
FAX: (213) 749-5348

PATIENT INTRODUCTION DATE_____

☐Mr.
☐Mrs.
☐Miss._____AGE_____
FIRST MIDDLE LAST

BIRTHDATE_____

☐SINGLE ☐MARRIED ☐SEPARATED ☐DIVORCED ☐WIDOWED

NAME OF PERSON LEGALLY RESPONSIBLE
(IF PATIENT IS A MINOR, NAME OF PARENT OR GUARDIAN, ETC)_____

HOME ADDRESS_____
STREET APT CITY ZIP

HOME PHONE_____ SOCIAL SECURITY_____

CELL PHONE_____ DRIVERS LICENSE _____

PATIENT EMPLOYED BY_____OCCUPATION_____PHONE _____

NAME OF SPOUSE_____AGE_____
FIRST MIDDLE LAST

SPOUSE EMPLOYED BY_____OCCUPATION_____PHONE_____

EMERGENCY CONTACT_____PHONE _____

REFERRED BY_____
FULL NAME

ADDRESS_____PHONE _____

ASSIGNMENT OF BENEFITS:
I assign all insurance benefits to Dr. Harry B. Kram. I understand that I am financially responsible for all charges whether or not paid by my insurance. I understand that Dr. Harry B. Kram's office is not responsible to know my plan, what it will pay for, or deductible requirements. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I hereby give my consent for examination, treatment, and insurance billing. I authorize appointment confirmations to be left with any family member or on the answering machine (in the event that I am not at home.)
ALL IN COMPLIANCE WITH HIPPA

DATE_____ SIGNATURE_____

DIPLOMATE, AMERICAN BOARDS OF VASCULAR, ENDOVASCULAR AND GENERAL SURGERY

ACKNOWLEDGMENT OR RECEIPT OF NOTICE OF PRIVACY PRACTICES

I HEREBY ACKNOWLEDGE THAT I HAVE RECEIVED A COPY OF THIS MEDICAL PRACTICE'S NOTICE OF PRIVACY PRACTICES. I FURTHER ACKNOWLEDGE THAT I WILL BE OFFERED A COPY OF ANY AMENDED NOTICE OF PRIVACY PRACTICES.

SIGNATURE: _____ DATE: _____
PATIENT/RESPONSIBLE PARTY

PRINT NAME: _____

IF NOT SIGNED BY THE PATIENT, PLEASE INDICATE:

RELATIONSHIP: _____

NAME OF PATIENT: _____

List all medications you are currently taking:

Allergic to any medication(s)?