STEPHANIE K. KRAFT M.D., P.C.
COMPASSIONATE AND COMPREHENSIVE CARE

Patient Information

Please complete for EACH enrolling member

Name *first* *middle* *last*		Sex	DOB *mm/dd/yyyy*
Address	City	State	ZIP
Home phone #	Cell phone #	Work phone #	Email address
Preferred local pharmacy/Phone/Location		Mail-order pharmacy	Last 4 digits of SSN
Emergency contact	Phone #	Relationship to patient	
Primary insurance carrier			
Secondary insurance carrier, if applicable			
Would you like to communicate electronically with us? YES NO		*If yes, please complete the separate Electronic Messaging Agreement.*	
May we leave voice mail messages for you containing health information, including lab tests and results?		YES*	NO
*If YES, on which phone numbers (circle all that apply):		Home Cell	Work