KLEIN DERMATOLOGY & ASSOCIATES

PATIENT

PATIENT NAME ______________________________ BIRTH DATE ______________ AGE ________
LAST NAME FIRST NAME MIDDLE

ADDRESS ____ M F
STREET CITY STATE ZIP CODE GENDER

HOME PHONE ______________ WORK PHONE ______________ OTHER PHONE ______________

EMPLOYER ______________________________ CAN WE CONTACT YOU AT WORK? ☐ YES ☐ NO

HOW SHOULD WE CONTACT YOU? ☐ HOME PHONE ☐ EMAIL ☐ WORK PHONE ☐ ______________

MARITIAL STATUS ☐ MARRIED ☐ SINGLE ☐ WIDOWED ☐ DIVORCED SOCIAL SECURITY #______________

FAMILY PHYSICIAN: ______________________________ PHONE #______________

YOUR EMAIL ADDRESS______________________________ HOW DID YOU FIND US? ______________

SPOUSE/PARENT/PARTNER

SPOUSE/PARENT/PARTNER NAME ______________________________ BIRTH DATE: ______________

EMPLOYER ______________ EMPLOYER PHONE ______________SS # ______________

PRIMARY INSURANCE INFORMATION

INSURANCE CO. NAME AND ADDRESS: ______________________________

ID #: ______________ GROUP #:______________ CO-PAY $:______________

NAME OF PERSON WITH INSURANCE: ______________________________ BIRTH DATE: ______________

SECONDARY INSURANCE INFORMATION

INSURANCE CO. NAME AND ADDRESS: ______________________________

ID #: ______________ GROUP #:______________CO-PAY $:______________

NAME OF PERSON WITH INSURANCE: ______________________________ BIRTH DATE: ______________

NAME OF FRIEND OR RELATIVE OR GUARDIAN OR PARENT – NOT LIVING WITH YOU (FOR MEDICAL EMERGENCY)

NAME ______________________________ RELATIONSHIP: ______________

ADDRESS: ______________________________ PHONE #: ______________

I hereby authorize the release of all medical information necessary to process claims. I hereby authorize my insurance company to make payments directly to Klein Dermatology and Associates. I am personally responsible for any balance due on my account. If my insurance company requires a referral for this or future visits, and one is not obtained, I will be responsible for any changes incurred. I guarantee payment for all charges, whether or not paid for by insurance.

SIGNATURE ______________________________ DATE ______________

WOULD YOU LIKE TO BE ADDED TO OUR NEWSLETTER MAILING LIST? ☐ YES ☐ NO