☐ NEW REGISTRATION

KLEIN DERMATOLOGY & ASSOCIATES

☐ UPDATED REGISTRATION

PATIENT INFORMATION

LAST NAME | FIRST NAME | MI | BIRTH DATE | AGE | SEX ☐ MALE ☐ FEMALE

HOME ADDRESS | CITY | STATE | ZIP

HOME PHONE # | CELL PHONE # | WORK PHONE - May we contact you here? | PREFERRED METHOD OF CONTACT: ☐ CELL ☐ HOME ☐ WORK ☐ OTHER

EMAIL

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

SOCIAL SECURITY#

MARITAL STATUS: ☐ MARRIED ☐ SINGLE ☐ WIDOWED ☐ DIVORCED ☐ OTHER

EMPLOYER | PRIMARY CARE PHYSICIAN | REFERRING PHYSICIAN

RESPONSIBLE PARTY INFORMATION (financial responsibility)

LAST NAME | FIRST NAME | MI | PRIMARY PHONE ☐CELL OR ☐HOME

ADDRESS | CITY | STATE | ZIP

RELATIONSHIP TO RESPONSIBLE PARTY ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER | EMPLOYER | WORK PHONE

EMERGENCY CONTACT INFORMATION

SPOUSE/PARTNER/PARENT | PHONE

INFORMATION

HOW DID YOU FIND US?

INSURANCE INFORMATION - SUBSCRIBER PARTY INFORMATION

PRIMARY INSURANCE | **SUBSCRIBER NAME** | DATE OF BIRTH

IDENTIFICATION NUMBER | GROUP NUMBER | COPAY

ADDRESS | CITY | STATE | ZIP | PHONE

SECONDARY INSURANCE | **SUBSCRIBER NAME** | DATE OF BIRTH

IDENTIFICATION NUMBER | GROUP NUMBER | COPAY

ADDRESS | CITY | STATE | ZIP | PHONE

PHARMACY

NAME AND LOCATION | PHONE | FAX

MANDATORY - PER NEW CMS GUIDELINES

LANGUAGE

☐ ENGLISH ☐ SPANISH
☐ RUSSIAN ☐ CREOLE
☐ OTHER ____________________

ETHNICITY

☐ LATINO/HISPANIC
☐ NON-LATINO/NON-HISPANIC

RACE

☐ BLACK/AFRICAN-AMERICAN ☐ ASIAN ☐ CAUCASIAN
☐ HISPANIC ☐ NATIVE HAWAIIAN ☐ OTHER PACIFIC ISLANDER
☐ AMERICAN INDIAN/ALASKA NATIVE ☐ OTHER ☐ REFUSE TO REPORT

DO YOU USE TOBACCO? ☐ NO ☐ YES - DURATION? | TYPE?