

**Patient s Information**

Patient Name		Nick Name	Social Security #	
Address		City, State, Zip		
Home Phone	Cell Phone	Birth date	Age	
School	Grade	Driver s License #	<input type="checkbox"/> F <input type="checkbox"/> M	
Employer (if employed)		Business Phone		
Address		City, State, Zip		
Who may we thank for referring you here today?		Email Address		

**Mother s Information**

Name	Occupation	Birth date	Social Security #	
Employer		Business Phone		
Address		City, State, Zip		

**Father s Information**

Name	Occupation	Birth date	Social Security #	
Employer		Business Phone		
Address		City, State, Zip		

**In Case of Emergency (other than parents)**

Person to Contact	Relationship	Day Phone	Home Phone
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**Primary Insurance and Financial Information (must be completed)**

Name of Insurance or HMO	Coverage	<input type="checkbox"/> Individual	<input type="checkbox"/> Group	<input type="checkbox"/> Medicare Supplement
Insured s Name	Social Security #			
Certificate #	Group or Policy #	Effective Date of Coverage	Expiration Date	

**Additional or Secondary Insurance**

Name of Insurance or HMO	Coverage	<input type="checkbox"/> Individual	<input type="checkbox"/> Group	<input type="checkbox"/> Medicare Supplement
Insured s Name	Social Security #			
Certificate #	Group or Policy #	Effective Date of Coverage	Expiration Date	

**Release of Medical Information:**

I am the parent or legal guardian of the above-named patient. I authorize the release of any medical information necessary for care or treatment or to process an insurance claim.

Signed \_\_\_\_\_ Date \_\_\_\_\_

**Responsibility for Payments and Assignment:**

My insurance is a contract between the insurance company and myself. I understand that I have full financial responsibility for all professional services rendered. I agree to remit appropriate co-payments or charges at time of service. I also hereby authorize my insurance benefits to be paid directly to Jeffrey F. Klein, M.D., Inc.

Signed \_\_\_\_\_ Date \_\_\_\_\_

Printed Name \_\_\_\_\_

**Treatment of a Minor:** I, the undersigned parent or legal guardian of the above listed minor, do hereby authorize Jeffrey F. Klein, M.D. and his staff to perform any medical or surgical care or treatment which is deemed advisable, in the office or hospital. This consent shall remain in effect until legal age, unless revoked in writing.

Signed \_\_\_\_\_ Date \_\_\_\_\_