

Patient Information			
Patient Name		Nick Name	Social Security #
Address		City, State, Zip	
Home Phone	Cell Phone	Birth date	Age
Occupation		Driver's License #	<input type="checkbox"/> F <input type="checkbox"/> M <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Widow
Employer		Business Phone	
Address		City, State, Zip	
Who may we thank for referring you here today?		Email Address	
Spouse Information			
Name		Occupation	Birth date
Employer		Business Phone	
Address		City, State, Zip	
Children			
Name		Birth date	Age
			If living at home, is Dr. Klein their physician? <input type="checkbox"/> Yes <input type="checkbox"/> No
Name		Birth date	Age
			If living at home, is Dr. Klein their physician? <input type="checkbox"/> Yes <input type="checkbox"/> No
Name		Birth date	Age
			If living at home, is Dr. Klein their physician? <input type="checkbox"/> Yes <input type="checkbox"/> No
Name		Birth date	Age
			If living at home, is Dr. Klein their physician? <input type="checkbox"/> Yes <input type="checkbox"/> No
In Case of Emergency (other than spouse)			
Person to Contact		Relationship	Day Phone
			Home Phone
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
Spouse's or Additional (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
<b>IMPORTANT: If you are here today (or in the future) because of an illness or injury that is work-related or the result of an auto accident or personal injury, please tell the receptionist. Your regular insurance may not cover your office visit and we want to keep you from having to pay.</b>			
<b>Release of Medical Information:</b> I authorize the release of any medical information necessary for care or treatment or to process an insurance claim.		_____ Signed _____ Date _____	
<b>Responsibility for Payments and Assignment:</b> 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	