☐ NEW REGISTRATION

KLEIN DERMATOLOGY & ASSOCIATES

☐ UPDATED REGISTRATION

PATIENT INFORMATION

LAST NAME	FIRST NAME	MI	BIRTH DATE	AGE	SEX ☐ MALE ☐ FEMALE ☐ NON-BINARY

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 for newsletters and specials? ☐ 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	BIRTH DATE	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 HEAR ABOUT 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	ETHNICITY	RACE
☐ ENGLISH ☐ SPANISH ☐ RUSSIAN ☐ CREOLE ☐ OTHER _____	☐ LATINO/HISPANIC ☐ NON-LATINO/NON-HISPANIC	☐ 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?

ASSIGNMENT OF BENEFITS AND RECORDS RELEASE

ASSIGNMENT OF BENEFITS

I understand I am financially responsible for services rendered regardless of insurance or other third party payer. Unpaid balances are subject to collection fees as well as legal fees if applicable. Also, I understand that I may be financially responsible for a cancellation fee of up to $150 should I fail to cancel/reschedule at least **48 hours in advance.**

I hereby authorize direct payment to Klein Dermatology & Associates of any medical benefits payable to me for the services provided at Klein Dermatology & Associates. I also understand that if my insurance plan requires a referral authorization for my appointments, it is my responsibility to obtain a referral prior to appointment. I will be responsible for the unpaid balance due and any bills if this is not done.

X_____

Patient Signature or Signature of Guardian or Parent Date

RECORDS RELEASE

I hereby authorize Klein Dermatology & Associates to release my records to my insurance company, 3rd party authorization company and/or primary care physicians for the purpose of processing my insurance claims. This authorization shall remain in effect as long as charges are being submitted for insurance claim processing or as long as dictated by payer.

X_____

Patient Signature or Signature of Guardian or Parent Date

Would you like to receive our paper newsletter and special promotions? ☐ YES ☐ NO

REVISED 6/2018