Lorrie J. Klein, M.D., A Professional Corporation

Diplomate, American Board of Dermatology

Welcome to our office… NEW PATIENT INFORMATION RECORD

PATIENT

Name _____
Last First M.I.

What do you prefer to be called? _____

Soc. Sec No. _____

Birth Date _____ Age _____

Street _____

City _____ State _____ Zip _____

Phone _____ Cell _____

E-mail Address _____

Driver Lic. No. _____

Sex: F M Marital Status: S M D W

Credit Card and No. _____

RESPONSIBLE PARTY (self it 18 or over)

Name _____

Soc. Sec No. _____

Street _____

City _____ State _____

Zip _____ Phone _____

Relationship _____

PRIMARY INSURANCE COMPANY

Carrier _____

Claim Office _____

Street _____

City _____ State _____

Zip _____ Phone _____

REFERRED BY (specify all that apply)

Doctor _____ Friend or Relative _____

Insurance _____ Yellow Pages _____

News Ad/Magazine _____ Spa _____

Internet
Google or other Search Engine: _____
Internet Yellow Pages _____ Realself.com _____
Our Websites ____ Other internet site: _____

Mailer/Postcard: _____ Other : _____

EMPLOYED BY

Name _____

Street _____

City _____ State _____

Zip _____ Phone _____

Occupation _____

SPOUSE

Name _____

Employed By _____

Work Phone _____

NEAREST RELATIVE NOT LIVING WITH YOU

Name _____

Phone _____ Relationship _____

COVERAGE TYPE

PPO: YES _____ NO _____

PRIMARY INSURED

Name _____

Soc. Sec No. _____

Medicare No. or I.D. No. _____

Birth Date _____

Group No. or Policy No. _____

Deductible _____

Co-pay per visit (if applicable) _____

MEDICAL INFORMATION

Drug Allergies _____

Current Medications _____

Medical Illnesses _____

Have you ever had skin cancer? Y _____ N _____

Pre-Cancers of the skin? Y _____ N _____

Has Dr. Klein treated you previously? Y _____ N _____

For what condition? _____

Has a family member been treated here? Y _____ N _____

Name _____

CANCELLATION POLICY:

I understand and agree that I will inform the office if I need to cancel my appointment, at least 1 business day in advance or I may be charged a cancellation fee ranging from $25.00 to $100.00 depending on the nature and length of the appointment.
Initial _____ Date _____

ASSIGNMENT OF BENEFITS

I directly assign all medical/surgical benefits to Lorrie J. Klein, M.D., and understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original. In the event of defaults, I agree to pay reasonable collection charges and/or attorney fees.

SIGNATURE _____ DATE _____

CONSENT TO EXAMINE AND TREAT: I give my consent for examination and treatment.

SIGNATURE _____ DATE _____