Dr. Jeffrey Klein Dermatology Patient Information Record 2015 11 20

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Patient Information

Name_____
Last First MI

Home #_____Cell #_____

Home Address_____

_____
City State ZIP

☐Male ☐Female Age____ Birth Date_____

☐Single ☐Married ☐Divorced ☐ Widowed

E-mail_____

Can we email you? ☐ Yes ☐ No

Social Security Number_____

Referred to Our Office by_____

Occupation _____Employer_____

Pharmacy_____Phone_____

Spouse or Parent Information

Name _____Phone_____

Person to Call In Case of Emergency

Name _____Phone_____

Medical History

Please check **yes or no** then **circle all** that apply

Yes No

☐ ☐ **Melanoma:** Personal **and/or** Family History?

Do YOU have a Personal History of the following?

☐ ☐ **Basal Cell** or **Squamous Cell Carcinoma**
☐ ☐ **Excessive Bleeding** from Cuts or Surgery
☐ ☐ History of **Skin Infections or MRSA**
☐ ☐ Have you ever **fainted or almost fainted**
☐ ☐ **Asthma, Hayfever, Eczema**
☐ ☐ **Heart Disease** or **Irregular Heart Beats**
☐ ☐ **High Blood Pressure**
☐ ☐ **Cardiac Pacemaker** or **Artificial Joint**
☐ ☐ **Hepatitis/Liver Disease**
☐ ☐ **Diabetes, Kidney** or **Thyroid Disease**
☐ ☐ **HIV Infection** or **AIDS**
☐ ☐ **Do you Smoke** or Use Tobacco Products

Comments:_____

Medical History (continued)

Current and/or Past Medical Conditions:_____

_____

List Previous Surgeries:_____

_____

Medication Allergies (please put NONE if no Med allergies):

Date:_____ Allergies:_____

What Happens: _____

Name of Primary Insurance Company

Insurance Co. Name:_____

Insured Person / Financially Responsible Party

Primary Insured Person: (Check One)

☐Patient (if patient skip this section)☐Spouse ☐Parent ☐Other

Name_____
Last First MI

Home #_____Soc Sec # _____

Birth Date_____ Age _____ ☐Male ☐Female

Employer _____Work#_____

Home Address: _____

_____
City State ZIP

Do you have **Secondary Insurance?** ☐Yes ☐No

If **YES**, **Who** Is The Primary On The Secondary Insurance?

Name_____ Date of Birth_____

Consent for Exam & Treatment / Assignment of Benefits

I give my consent for examination, treatment, biopsy &/or excision, and the exchange of medical information for purposes of medical treatment & second opinions. I hereby assign all medical benefits to which I am entitled to Jeffrey Klein, MD, Inc. I understand that I am financially responsible for all charges incurred, whether or not paid by insurance. I authorize the release of any necessary medical information to my insurance carrier to process my claim. I acknowledge that I have received a copy of the Notice of Privacy Practices. I agree to be charged $25 no-show/cancellation fee if I miss an appointment without notifying the office at least 24 hours prior to my appointment. I attest that the information I provided on this form is correct.

_____ _____
Signature Date

Below is for Review and/or Updates (Please Date & Initial)

_____ _____ _____ _____
Date Initials Date Initials