REGISTRATION FORM

Date: ____

Marital Status: Single Married Divorced Separated Domestic Partner Widow

Male / Female

Name of Patient: ____ DOB: _________________

Social Security Number: ____

Home/Cell Phone Number: ____

Preferred number: ____

Home Address: ____

Space/Apt.: _______ City: ______________________ State: _______ Zip code: _____________

*If you have a different billing address, please provide information:

____

____

____

PRIMARY CARE PROVIDER (Primary doctor): ____

REFERRING PROVIDER (if different from primary): ____

PHONE: (520) 290-0961 **FAX: (520) 290-0965**

MAIN OFFICE

San Rafael Professional Offices
6618 E. Carondelet Drive
Tuscon, AZ 85710

Satellite Offices:

905 W. Bowie Avenue
Willcox, AZ 85643

1209 W. Target Range Road
Nogales, AZ 85621

450 W. Continental Road
Green Valley, AZ 85622

INSURANCE INFORMATION

(Even though we get a copy of your card(s) we still need this information filled out)

PRIMARY Insurance: ______________________________

Member ID Number: ______________________ Group Number: ______________________

Name of Policy Holder: ______________________ DOB: ______________

Relationship to Patient: Self Spouse Domestic Partner Parent

SECONDARY Insurance: ______________________________

Member ID Number: ______________________ Group Number: ______________________

Name of Policy Holder: ______________________ DOB: ______________

Relationship to Patient: Self Spouse Domestic Partner Parent

TERTIARY Insurance: ______________________________

Member ID Number: ______________________ Group Number: ______________________

Name of Policy Holder: ______________________ DOB: ______________

Relationship to Patient: Self Spouse Domestic Partner Parent

PLEASE READ AND SIGN:

*I consent to allow Dr. John Klein, MD, PC to use and disclose my Protected Health Information in order to carry out medical treatment, payment, and healthcare operations.
*I authorize Dr. John Klein, MD, PC to provide medical information to my insurance carrier and I authorize payment of insurance benefits to Dr. John Klein, MD, PC for services provided to me.
*I have received a copy of Dr. John Klein, MD, PC Notice and Privacy Practice on the date indicated below.

Patient / Legal Guardian Signature: ______________________________

Date: ______________________________

Is this a work-related injury? Yes / No

If yes please provide: Employer Name and Address, WC Insurance Policy Number/Claim Number, Insurance Address, and Adjuster's Name and Phone Number.

____
____
____
____
____
____

PAST MEDICAL HISTORY

Please list any surgeries you have had:

___

___

___

Did you have general anesthesia? Yes No

Did you have any problems with the anesthesia? If yes, please explain:

___

___

FAMILY HISTORY

Mother	Alive/health problems: Alive/healthy	Deceased (cause of death:)
Father	Alive/health problems: Alive/healthy	Deceased (cause of death:)

SOCIAL HISTORY

Employed (occupation ____________) Self-employed Student Retired Work at home

Do you have any children? No / Yes If yes, how many? ____________

Do you live alone? No Yes

Do you exercise? If yes, what type of exercise? ____________

Do you have a history of substance abuse? If yes, what type? ____________

Do you smoke? Quit ______ years If yes, how long? ____________

Do you drink alcohol? If yes, what type? ____________ how often ______ / Social

PATIENT OR LEGAL REPRESENTATIVE SIGNATURE:

____________ Date______

REVIEWED BY:

____________ Date______