JOHN KLEIN MD
ORTHOPEDIC SURGEON

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:

1209 W. Target Range Road
Nogales, AZ 85621

450 W. Continental Road
Green Valley, AZ 85622

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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.

_____
_____
_____
_____
_____
_____

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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_____