



## 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

1131 S. La Canada Drive, Suite 201  
Green Valley, AZ 85614



## 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:

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Did you have general anesthesia?    Yes        No

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

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## 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 \_\_\_\_\_