



**YUILL BLACK, M.D. AND MICHAEL R. KLETZ, M.D., P.C.**

Allergy ♦ Asthma ♦ Immunology

Today's Date \_\_\_\_\_

New Patient  Update information  TY  DC  MN Patient Acct No. \_\_\_\_\_ Staff ID \_\_\_\_\_

**PATIENT INFORMATION**

|  |  |
|--|--|
| Name: Last First MI  | Marital status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Other |
| Social Security No.  | Home # Work #  |
| Birth Date Sex <input type="checkbox"/> M <input type="checkbox"/> F Age | Cell #   |
| Address  | Email Address  |
| City, State, Zip   | Referred By  |
| Primary Care Physician   | Physician Address  |

**RESPONSIBLE PARTY INFORMATION**  Check ONLY if same as patient

|                     |  |
|---------------------|--|
| Name: Last First MI | Birth Date Sex <input type="checkbox"/> M <input type="checkbox"/> F |
| Home #              | Address  |
| Cell #              | City, State, Zip   |
| Work #              | Relationship to Patient  |

**PRIMARY INSURANCE COVERAGE** \*PROVIDE SECONDARY COVERAGE ON BACK OF FORM

|  |  |
|--|--|
| Subscriber Name (Primary Policyholder) | Relationship to patient <input type="checkbox"/> Same <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Other |
| Social Security No.                    | Birth Date Sex <input type="checkbox"/> M <input type="checkbox"/> F   |
| Insurance Company                      | Effective Date of Coverage   |
| ID/Policy No. Group No.                | Referral Required <input type="checkbox"/> Yes <input type="checkbox"/> No   |

**IN CASE OF EMERGENCY, Notify**

|        |                         |
|--------|-------------------------|
| Name   | Relationship to patient |
| Home # | Cell # Work #           |

**CONSENT TO TREAT, RELEASE MEDICAL INFORMATION, AND ASSIGNMENT OF INSURANCE BENEFITS**

I acknowledge seeking medical care, and consent to treatment. I request payment of insurance benefits (including Medicare benefits) be made to me or on my behalf to Yuill Black, MD & Michael R. Kletz, MD, PC for any services furnished me by that physician/physician group who accepts this assignment. I consent to using or disclosing my personal health information to carry out treatment, payment or health care operations to any holder of medical information about me including, but not limited to my insurance carrier (or in the care of Medicare, to the Center for Medicare and Medicaid Services (CMS) and its agencies) to determine benefits payable for related services. I permit a copy of this consent to be used in place of the original. Either I, or my insurance carrier may revoke this consent, at any time in writing. I accept responsibility for any balance due on services rendered.

Signature of Patient (or Beneficiary if patient is under 18 years of age) \_\_\_\_\_ Date \_\_\_\_\_

**THIS FORM MUST BE UPDATED ANNUALLY AND SIGNED AND DATED TO ALLOW US TO SUBMIT INSURANCE ON YOUR BEHALF**