



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