STEFAN KLEIN, M.D.

1505 Soquel Drive, Suite 10
Santa Cruz, CA 95065
T: (831) 462-4801 F: (831) 462-4756

Patient: _____
Last Name First Name Initial

Address: _____
Mailing Address City State Zip

( ) Home ( ) Cell Phone: _____ Driver's License: _____ SS#: _____

Sex: ( ) M ( ) F Age: _____ Birth Date: _____ ( ) Single ( ) Partner ( ) Married ( ) Divorced ( ) Widowed

Employer: _____ Occupation: _____

Address: _____
Street City State Zip

( ) Yes, send a copy of today's chart notes to:

Primary Physician: _____ Referring Physician: _____

SPOUSE OR DOMESTIC PARTNER INFORMATION

Name: _____ ( ) Home ( ) Cell Phone: _____ Sex: ( ) M ( ) F

SS#: _____ Birth Date: _____ Employer/Occupation: _____

Address: _____
Street City State Zip

EMERGENCY CONTACT INFORMATION ( ) Same as above

Name: _____ Phone: _____ Relationship: _____

INSURANCE INFORMATION *Office Use Only * Do Not Fill Out.*

( ) Primary Insurance Co.: _____ Subscriber ID: _____ Insured: ( ) Self ( ) Spouse

Claims Address: _____
Mailing Address City State Zip

( ) Secondary Insurance Co.: _____ Subscriber ID: _____ Insured: ( ) Self ( ) Spouse

Claims Address: _____
Mailing Address City State Zip

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize payment directly to Dr. Stefan Klein, 1505 Soquel Dr. Ste 10, Santa Cruz Ca 95065 for professional services rendered. I do understand that I am financially responsible for any amounts that are not fully paid by my insurance company.

Signature: _____
Responsible Party Date

MEDICARE PATIENTS

I understand my signature requests that payment be made to Dr. Stefan Klein, MD. 1505 Soquel Dr. Ste 10, Santa Cruz Ca 95065 and authorizes release of medical information necessary to pay the claim. If other health insurance coverage is indicated in item 9 of the HCFA – 1500 claim form or elsewhere on the other approved claim forms or electronically submitted claims, my signature authorizes release of information to the insured or agency.

Signature: _____
Responsible Party Date

PLEASE CONTINUE - - >