THOMAS E. KLEIN, MD PC NEIL BAMAN, MD MICHAEL PREMATTA, MD TRACY PREMATTA, MD

ADULT AND PEDIATRIC ALLERGY
ASTHMA AND CLINICAL IMMUNOLOGY

400 W TOWNSHIP LINE RD
HAVERTOWN, PA 19083
610-789-1313
FAX 610-789-0655

LANKENAU MEDICAL BLDG
100 E. LANCASTER AVE, SUITE 551 E
WYNNEWOOD, PA 19096
610-896-5600

RIDDLE MEMORIAL HOSPITAL
HEALTH CENTER 2, SUITE 2106
MEDIA, PA 19063
610-566-2126

NEW PATIENT REGISTRATION FORM

Please print this form, fill it out and bring it with you when you come in for your first visit or fax it to us at 610-789-0655 before your first visit.

1. WHO IS THE PATIENT?

First name Last Name
Street Address
City State Zip
Phone # Home
Phone # Work SS#
Date of Birth

2. WHO IS THE GUARANTOR? (WHOSE NAME SHOULD THE ACCOUNT BE UNDER?)

First name Last Name
Street Address
City State Zip
Phone # Home
Phone # Work SS#
Date of Birth

3. INSURANCE INFORMATION

Insurance company
Group #
Policy #
Do you need referral forms? ☐ Yes ☐ No
What is your co-pay?

SECONDARY INSURANCE

Insurance company
Group #
Policy #

4. REFERRING PHYSICIAN OR PRIMARY CARE PROVIDER

(We would like to send a medical summary letter to them)

Name
Street Address
City State Zip
Phone #

If your doctor didn't refer you to us then who did?

☐ Google ☐ I saw the office sign
☐ a friend ☐ advertisement
☐ a relative ☐ yellow pages
☐ you are on my insurance provider panel
☐ other (please specify)

Please remember the following:

1. **DO NOT TAKE ANY ANTIHISTAMINES FOR 2 DAYS BEFORE THE FIRST VISIT.**
2. **PLEASE CONTINUE ALL OF YOUR OTHER MEDICATIONS.**
3. **PLEASE BRING IN YOUR MEDICINES OR A LIST OF YOUR MEDICINES.**
4. **PLEASE BRING IN RECENT LAB TESTS, CT SCAN REPORTS AND CHEST X-RAY REPORTS.**

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AUTHORIZATION FOR THE USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I authorize the use and/or disclosure of my protected health information as described below:

1. My authorization applies to my medical record. Only this information may be used and/or disclosed pursuant to this authorization.

2. I authorize Dr. Klein and his staff to make the authorized use and/or disclosure of my protected health information.

3. I authorize my insurance company and my physicians to receive my protected health information.

4. I understand that, if my protected health information is disclosed to someone who is not required to comply with the federal privacy protection regulations, then such information may be re-disclosed and would no longer be protected.

5. I understand that I have a right to revoke this authorization at any time. My revocation must be in writing to Dr. Klein. I am aware that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my protected health information have acted in reliance upon this authorization.

6. This authorization expires if I am no longer a patient of Dr. Klein.

7. I understand that I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment from Dr. Klein, nor will it affect my eligibility for benefits.

8. My protected health information will be used or disclosed upon request in order for payment of authorized Medicare or commercial insurance benefits to be made to me or on my behalf to Dr. Klein for any services furnished to me by Dr. Klein.

9. I understand that I have a right to inspect and copy my own protected health information to be used or disclosed, (in accordance with the requirements of the federal privacy protection regulations found under 45 C.F.R. §164.524).

I certified that I have received a copy of the authorization.

_____ _____

Signature of Patient/Guardian Date

_____ _____

Printed Name of Patient /Guardian Relationship to Patient

_____

Name of Patient if different from above