

JOSEPH L. KIENER, M.D.

**If you have been a patient here before under a different name, please indicate name below:

REASON FOR VISIT: _____ **DATE:** _____

PATIENT INFORMATION

MR MRS MS (Circle one)

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Social Security No.: _____

Employer Full Name: _____ [] Full-time [] Part-time

Marital Status:

[] Single [] Divorced

[] Married [] Widow(er)

Sex: M F (Circle one)

Age _____ Birthdate _____

Home Phone: () _____

Work Phone: () _____

FINANCIALLY RESPONSIBLE PARTY (If different from patient)

MR MRS MS (Circle one)

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Social Security No.: _____

Employer Full Name: _____ [] Full-time [] Part-time

Relationship:

[] Parent [] Spouse [] Other

Occupation:

Home Phone: () _____

Work Phone: () _____

1st INSURANCE

Insurance Company Name: _____

Address (We bill all insurance for all patients): _____

Name of Insured: _____

Social Security No.: _____

Employer: _____

Policy/Group No.: _____

Relationship to Patient: _____

Insured's Birthdate: _____

2nd INSURANCE

Insurance Company Name: _____

Address (We bill all insurance for all patients): _____

Name of Insured: _____

Social Security No.: _____

Employer: _____

Policy/Group No.: _____

Relationship to Patient: _____

Insured's Birthdate: _____

Local Friend/Relative: _____

Address: _____

Were you injured at work? _____

Allergies: _____ Family Physician: _____

Do you have any contagious or infectious diseases? _____

If yes, specify: _____

Have you been exposed to the AIDS virus? _____

Have you been tested positive for the AIDS virus? _____

Have you been tested positive for hepatitis? _____

Relationship: _____

Phone: () _____

Date of Injury: _____

Referred Here By:

[] Yellow Pages

[] Friend [] Relative

[] NV State Medical Assoc.

[] County Medical Society

[] Attorney (Name): _____

[] Doctor (Name): _____

[] Hospital (Name): _____

[] Other _____

Assignment and Release of Records

I Hereby authorize payment directly to Joseph L. Kiener, M.D. for any monetary benefits from my medical surgical plans. I fully understand that I am responsible for my account regardless of insurance involvement. I hereby authorize Joseph L. Kiener, M.D. to release my medical records to my insurance companies. I give permission for the use of my photographs or X-rays in medical lectures or publications for scientific purpose. I have received the Notice of Privacy Practices and I have been provided the opportunity to review it. Note: All unpaid accounts over 90 days will accrue interest at 18% per annum.

Date: _____ Signature: _____