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 ☐ Single ☐ Married ☐ Other
Social Security No.	Home # Work #
Birth Date Sex ☐ M ☐ 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 ☐ M ☐ 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 ☐ Same ☐ Spouse ☐ Parent ☐ Other
Social Security No.		Birth Date Sex ☐ M ☐ F
Insurance Company		Effective Date of Coverage
ID/Policy No.	Group No.	Referral Required ☐ Yes ☐ 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

2025