Paul H. Klenoff M.D.
804 West Park Avenue
Ocean, NJ 07712
(Building B)
732 493-3337

Directions from Howell, Jackson, Lakewood areas:

195 East To **18 North** take exit **11 A** (Deal Road) first traffic light make left onto Poplar, go to next light make right onto West Park Avenue, go thru one traffic light office is on the right

Directions from Manalapan, Marlboro, Freehold areas:

18 South to exit **12A** (West Park Avenue) continue thru 2 traffic lights office will be on the right hand side

Directions from Garden State Parkway:

Take exit **105** first traffic light make right onto Hope road, follow Hope road to the 3rd traffic light, make left at 3rd traffic light onto West Park Avenue continue thru 2 traffic lights office will be on the right

Please bring with you at time of appointment:

Insurance card, driver's license
Referral from primary Dr. if your plan requires one
Cash or Check only for your copayment (Our office **does NOT** take debit or credit cards)

PLEASE FILL OUT COMPLETELY (page 1 of 2)

TODAY'S DATE_____ REFERRING DOCTOR_____

PATIENT'S LAST NAME_____
PATIENT'S FIRST NAME_____ MI_____

Date of Birth (month/date/year) _____ Sex - Male____ Female _____

Marital Status Circle One S M W D Sep Last 4 digits SS # _____

STREET ADDRESS_____
CITY _____
STATE _____ ZIP CODE_____

Home Phone # ( ) _____Patient's cell # ( )_____
Work Phone # ( )_____
OCCUPATION_____
EMPLOYER _____

If patient is under age 18 parent / guardian name & cell #:

_____

SPOUSE'S NAME_____ Date of Birth_____

*****INSURANCE INFORMATION (MUST BE COMPLETED)**

PRIMARY INSURANCE COMPANY_____
INSURANCE ID #_____
Policy Holder's Name_____
Policy Holder's Relationship to Patient_____
Policy Holder's Date of Birth_____
Policy Holder's Address (if different from patient's) _____
City_____ State_____Zip_____
Policy Holder's Employer _____

SECONDARY INSURANCE _____
NAME OF POLICY HOLDER _____ Date of Birth_____

I certify that the information given by me is correct. I hereby authorize direct payment of surgical/medical benefits to Dr. Paul H. Klenoff for services rendered. I understand that I am financially responsible for any balance not covered by my insurance.

SIGNATURE_____

PLEASE LIST MEDICATIONS YOU ARE TAKING:

_____

_____

_____

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

PATIENT ACKNOWLEDGEMENT FORM

This form is your acknowledgement that we have informed you on how we may use and disclose health information about you. This notice informs you to the fact that every patient has the right to review the Notice of Privacy Practices. This notice is the outcome of HIPAA (Health Insurance Portability and Accountability Act of 1996), mandated by the federal government. The act will be come law by April 14, 2003. The Notice of Privacy Practices insures that your personal health information is kept private between insurance companies, doctors, hospitals, laboratories, and drug companies.

By signing this form, you consent to our use and disclosure of protected health information about your treatment, payment and healthcare operations.

By signing this form, you consent that our office may call your home or other designated location and leave a message on voice mail or in person to any items that assist the practice in carrying out treatment, payment, and healthcare operations such as appointment reminders, insurance items, etc.

_____ _____

Print Name of Patient **Date**

_____

Signature of Patient/Parent/Legal Guardian

Designation of Certain Relatives, and Other Caregivers:

I agree that the practice may disclose my health information to a family member, or caregiver, (example; spouse) since such person is involved with my health care or payment relating to my health care.
I designate the following person listed below as person involved with my health care or payment relating to my health care. I understand that I am not required to list anyone.

Print Name:_____ Birth date_____ Relationship to pt._____(spouse, daughter, son, fiancée etc.)
Signature of patient: _____

Please complete: Would you like a full body skin cancer exam?

************If you ARE scheduled for one today please check this box _____**

If you are NOT scheduled for one today, please check appropriate box below and you can schedule this with the front desk for a later date. This is covered by insurance and Dr. Klenoff recommends this exam.

_____ Yes _____No

****Please Give Insurance Card, Driver's License, and Co Payment (cash or check only) to the front desk with this completed form