Kathleen L Behr M D
1125 E Spruce Ave - Suite 207 - Fresno, CA 93720-3390
Phone: (559) 435-7546 • Fax: (559) 435-4976

Email: _____

Name: (First, Middle, Last) _____ **Date of Birth:** _____

Address: _____ **(City, State, Zip):** _____

Social Security #: _____ Sex: ☐ M ☐ F Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Home Phone: _____ **Cell Phone:** _____ Work Phone: _____ **Preferred Name:** _____

Maiden Name: _____ Employment Status: ☐ Employed ☐ Part-time Student ☐ Full-time Student ☐ Other

Employer: _____ Occupation: _____

Address: _____ (City, State, Zip): _____

Name: _____ Date of Birth: _____

Address: _____ (City, State, Zip): _____

Social Security #: _____ Responsible Party's Phone #: _____ Relationship to Patient: _____

Occupation: _____ Employer: _____ Employer Phone: _____

Name of Insured: _____ Relationship to Patient: _____

Insured's Date of Birth: _____ Social Security #: _____ Phone: _____

Insurance Company: _____ Group #: _____ ID Number: _____

Address: _____ (City, State, Zip): _____

Name: (First, Middle, Last) _____ Date of Birth: _____

Address: _____ (City, State, Zip): _____

Social Security #: _____ Employer: _____ Employer Phone: _____

Name: _____ Phone: _____ Relationship to Patient: _____

Address: _____ (City, State, Zip): _____

☐ Employment ☐ Emergency ☐ Accident ☐ Auto Accident (State of Auto Accident) _____

If Employment related, has employer been notified? ☐ Yes ☐ No Employer Contact Name: _____

Employer Contact Phone and Extension: _____

☐ By an Attorney ☐ By a Doctor ☐ By a Patient ☐ Yellow Pages ☐ Other

Please print the name of your source: _____

I voluntarily consent to receive medical and health care services that may include diagnostic procedures, examination, and treatment.
I hereby assign, transfer, and set over to Kathleen L Behr M D all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand that I am financially responsible for all charges whether or not they are covered by insurance.

I certify that I have read this form and understand its contents.

Patient or Other Legally Authorized Person:

_____ Date: _____