Date: JAN. 11, 2019

MITCHELL A KLINE [redacted] D.

PATIENT REGISTRATION

NAME: JEFFREY EPSTEIN

SOCIAL SECURITY: _____ DATE OF BIRTH 1-20-53 GENDER M

PREFERRED LANGUAGE: ENGLISH Marital Status: (S) M D W

RACE:
(CAUCASIAN) AMERICAN INDIAN 0R ALASKA NATIVE ASIAN BLACK OR AFRICAN AMERICAN NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER

ETHNIC GROUP:
HISPANIC OR LATINO NOT HISPANIC OR LATINO UNKNOWN

ADDRESS: 9 EAST 71ST ST.

CITY: NEW YORK STATE: NY ZIP CODE 10021

HOME# 212-750-9895 WORK# 212-750-9895

CELL# 212-533-3739 E-MAIL jeevacation@gmail.com

PHARMACY NAME VITAHEALTH ADDRESS 1235 1ST AVE.

PHONE# [redacted] FAX# 212-628-1117

OCCUPATION/EMPLOYER: SOUTHERN TRUST CO.

REFERRED BY: (PHYSICIAN, PATIENT, FRIEND, OR OTHER) PLEASE CIRCLE AND LIST

NAME: _____

SPOUSE/PARENT: _____

FINANCIAL/INSURANCE INFORMATION

Dr. Kline does not participate with any health insurance. I understand that I am responsible for all chargers incurred and that payment is due at the time services are rendered. We require a copy of your insurance card for laboratory purposes only.
I request that payment of authorized Medicare benefits be made either to me or on my behalf to Mitchell Kline, M.D. for services furnished to me by the provider. I authorize any holder of medical information about me to release to CMS and its agents any information needed to be determine these benefits payable for related services.

CARRIER NAME: UNITED HEALTHCARE ID# [redacted]

GROUP # 272605
Employer Sponsored? — Government Sponsored? —

RELATIONSHIP TO INSURED NAME: SELF

KINDLY GIVE 24HR HOURS NOTICE TO CANCEL APPOINTMENTS.
A FEE OF $100.00 WILL BE BILLED TO YOU FOR LESS THAN 24HOUR HOURS NOTICE AS WELL AS FAILURE TO KEEP SCHEDULED APPOINTMENTS.