Nephrology & Hypertension Associates of Alaska, PC

David M. Lefler, Jr., DO, FACP, FASN
American Board of Internal Medicine- certified Internal Medicine & Nephrology

PATIENT REGISTRATION FORM

Name (First, Middle Initial, Last): ____

Date of Birth (MM/DD/YYYY): ____________________ Gender (M/F): _________ SSN: _______________________

Mailing Address: ____
Street City State Zip

Email address: _____________________________________ (sensitive medical information is not emailed)

Phone number (s): _____________________________________ (May we leave medical message? Y / N)
Home

_____________________________________ (May we leave medical message/TEXT ? Y / N)
Cell

_____________________________________ (May we leave medical message? Y / N)
Work

Marital Status (circle): Unmarried Married Separated Divorced Widowed

Primary Language: ______________________________________ Translator required? Yes / No

Preferred Pharmacy: ____________________________________ Preferred Lab: ___________________________

Primary Physician: ______________________________________ Referring Physician: ______________________

Emergency Contact: ____
Name Relationship Phone

Others we may share your information with: ____
(HIPAA Auth form required) Name Relationship Phone

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Name Relationship Phone

Anchorage, AK Fairbanks, AK Juneau, AK
Phone: (907)770-0412 Fax: (844) 772-0725
Website: www.nhakidney.com

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Patient Employer Information

Status (circle): Employed Retired Disabled Student Self Employed
Employer's Name:
Employer's Address:
Employer's Phone:
Occupation:

Patient Insurance Information

Primary Insurance Name	ID #	Group/Policy #	
Insured/Policyholder Information (if different from patient)	Name ______________________	Relationship to Patient ______________________	
Employer ______________________	Date of Birth (MM/DD/YYYY) ______________________	Phone # ______________________	SSN ______________________

Secondary Insurance Name	ID #	Group/Policy #	
Insured/Policyholder Information (if different from patient)	Name ______________________	Relationship to Patient ______________________	
Employer ______________________	Date of Birth (MM/DD/YYYY) ______________________	Phone # ______________________	SSN ______________________

Certification of Accuracy

The above information is true to the best of my knowledge. I authorize Nephrology & Hypertension Associates of Alaska, PC to release any information (only as required) to process my insurance claims.

______________________ ______________________ ______________________

Patient or Guardian Signature **Printed Name** **Date**

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