Nephrology Specialists, P.C.
Kidney diseases and hypertension

PATIENT INFORMATION FORM

Please Print Clearly

PATIENT NAME: (Last Name, First Name, Middle Initial)	**DATE OF BIRTH:** (mm/dd/yy) / / — **GENDER:** Female Male
MAILING ADDRESS: (Street)	**PATIENT SOCIAL SECURITY#:**
CITY:	**STATE:** — **ZIP CODE:**
HOME PHONE: **MAY WE LEAVE A MESSAGE: Yes No** ( )	**CELL PHONE:** **MAY WE LEAVE A MESSAGE: Yes No** ( )
PREFERRED CONTACT NUMBER: (circle one) **HOME CELL**	**EMAIL:** **MAY WE SEND A MESSAGE: Yes No**
EMPLOYER NAME:	**EMPLOYER PHONE:** ( )
EMERGENCY CONTACT PERSON(other than spouse):	**EMERGENCY CONTACT PHONE:** ( )
RELATIONSHIP TO GUARANTOR:	**STATUS:** **Married Single Other**
REFERRED BY: **Dr:**	**REFERRED BY PHONE:** ( )

PRIMARY INSURANCE:	**POLICY NUMBER:**	**GROUP NUMBER:**
NAME OF INSURED: (If different from patient above)	**BIRTH DATE:**	
SECONDARY INSURANCE:	**POLICY NUMBER:**	**GROUP NUMBER:**
NAME OF INSURED: (If different from patient above)	**BIRTH DATE:**	

CONSENT AND AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original. I also hereby authorize and consent to the giving of all treatments, examinations, medications, and any technical procedures which in the judgment of Nephrology Specialists PC and/or their medical staff consider necessary or advisable for diagnosis or treatment.

I hereby authorize Nephrology Specialists PC to apply for benefits on my behalf for covered services rendered or orders. I request that payment from my insurance company be made directly to Nephrology Specialists PC (or to the party who accepts assignment). I understand that I am financially responsible for any balance not covered by my insurance.

I certify that the information I have reported with regard to my insurance coverage is correct. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or my insurance company at any time in writing. I understand that my insurance carrier may require precertification or authorization, for which I am responsible for acquiring. I understand that if all insurance requirements are not followed then I will be responsible for all charges incurred. I also understand and accept responsibility for service charges, late fees, and other costs, including but not limited to attorney fees incurred in collecting this account.

PATIENT'S SIGNATURE:	**DATE:** (mm/dd/yy)