**16407 Southfield Rd Ste A 14752 Northline Rd 5715 Venoy Rd 2050 N Haggerty Rd Ste 260**

**Allen Park, MI 48124 Southgate, MI 48195 Westland, MI 48185 Canton, MI 48187**

**313-271-3000 734-285-5030 734-513-2910 734-513-2910**

**313-271-3003 fax 734-285-8223 fax 734-513-6929 fax 734-513-6929 fax**

**PLEASE COMPLETE ALL PATIENT INFORMATION**

**NAME:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_ **DOB:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ADDRESS:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_ CITY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ STATE: \_ \_\_\_ ZIP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

HOME PHONE: \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ CELL PHONE: \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ WORK PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MARITAL STATUS: S M W D (CIRCLE) **SOCIAL SECURITY NUMBER:** \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMAIL: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CURRENT EMPLOYER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_ IF RETIRED, DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**EMERGENCY CONTACT NAME:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_ RELATIONSHIP: \_\_\_ \_ \_\_\_\_\_\_\_

EMERGENCY CONTACT HOME PHONE: \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CELL PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_

**PRIMARY INSURANCE PLAN**: \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_

SUBSCRIBER ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SUBSCRIBER GROUP:

SUBSCRIBER NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ SUBS DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_ \_\_\_\_

**SECONDARY INSURANCE PLAN**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SUBSCRIBER ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ SUBSCRIBER GROUP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SUBSCRIBER NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ SUBS DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_ \_\_\_\_\_

**PHARMACY (PRIMARY AND SECONDARY NAME AND CITY):**

**REFERRING PHYSICIANS NAME**, ADDRESS, AND PHONE NUMBER:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PRIMARY CARE PHYSICIANS NAME**, ADDRESS, AND PHONE NUMBER:

I hereby authorize **NEPHROLOGY HYPERTENSION CLINIC, PC** to submit claims to my insurance carrier and release any information needed for processing of claims related to medical services performed in accordance with HIPAA.

I hereby assign benefits for physician services to **NEPHROLOGY HYPERTENSION CLINIC, PC**.

I hereby authorize **NEPHROLOGY HYPERTENSION CLINIC, PC** to administer such treatment and perform such procedures necessary or advisable for the diagnosis and treatment to the undersigned patient.

I understand that I am financially responsible to **NEPHROLOGY HYPERTENSION CLINIC, PC** for any services not covered by my insurance carrier.

A copy of this signature is as valid as the original.

**DATE**: **SIGNATURE:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (PATIENT, PARENT OR GUARDIAN)