Nephrology P.A. CONSULTANTS
3024KIDNEY.com

Patient Registration

DEMOGRAPHIC INFORMATION

Today's Date	First Name		Last Name	MI	Gender
Street Address			City, State		Zip Code
Date of Birth	Age	Social Security #	Occupation		Marital Status

Home Phone #	Cell Phone #	Work Phone #
Email Address		
Driver's License OR Identification ID card No:	State/Place of Issue:	Expires on

EMERGENCY CONTACT

Name:	Relation to Patient

Home Phone #	Cell Phone #	Work Phone #

PHARMACY

Name:	Main Phone #	Location #

INSURANCE INFORMATION

COPY OF INSURANCE CARD & PHOTO ID
If your insurance coverage is under another person's name, please note their name and date of birth:

Name of Policy Holder	**Date of Birth**

AUTHORIZATION AND ASSIGNMENT OF BENEFITS:

I give permission to Nephrology Consultants, P.A. and its employees, agents, and medical providers to release medical information to insurance carriers, health organizations, governmental agencies (including Center for Medicaid and Medicare Services - CMS), and other entities charges with fiscal responsibility for the payment of medical services rendered to me. I hereby authorize payment of the medical benefits otherwise payable to me, be directed to Nephrology Consultants, PA or appropriate provider. I consent to have any monies received by the provider of services on my behalf to be applied to my outstanding accounts. I assume full responsibility for payment of charges for the medical services provided. I understand that my medical information may be electronically submitted to any or all treating physicians, hospitals, and or health care entities. I take responsibility of providing Nephrology Consultants with true, complete and accurate information regarding my medications, health condition(s), ongoing treatments and recommendations of other providers. Also, I promise to follow their recommendations including medications, tests and follow-up visits.

Signature: _____ **Date:** _____

Relation to Patient: _____