

DATE: _____

PATIENT INFORMATION FORM

NAME:

Last First Middle

ADDRESS:

Street

City State Zip Code

PHONE:

Home

Work

Social Security #

Date of Birth

MARITAL STATUS: S M D W
(Circle One)

Spouse's Name _____

Spouse's SS # _____

Employer Name:

Employer Address

Pharmacy Name

Pharmacy Phone #

Primary Physician

Primary Physician Phone #

Referring Physician

Referring Physician Phone#

Home Health or Visiting Nurse

Contact Name & Phone #

Nursing Home Name

Nursing Home Phone #

EMERGENCY CONTACT:

Name

Phone Number

NEPHROLOGY PHYSICIANS, LLC
710 Park Place
Mishawaka, IN 46545
www.nephinc.com

RESPONSIBLE PARTY (if other than patient):

Name:

Last First Middle

Street Address

City State Zip Code

Home Phone # Work Phone #

Social Security # Date of Birth

MARITAL STATUS: M S D W

(Circle One)

Employer Name Employer Street Address

City State Zip Code

INSURANCE INFORMATION

PRIMARY INSURANCE:

Name Address

City State Zip Code

Phone # Policy # Group #

SECONDARY INSURANCE:

Name Address

City State Zip Code

Phone Policy # Group #

NEPHROLOGY PHYSICIANS, LLC
710 Park Place
Mishawaka, IN 46545
www.nephinc.com

AUTHORIZATION TO RELEASE INFORMATION

I Hereby authorize Nephrology, Inc. physician(s) to release all information acquired in the course of my examination and/or treatment to process insurance claims.

Signature Date

AUTHORIZATION TO PAY BENEFITS

I hereby authorize payments to Nephrology, Inc. of the medical benefits, if any, otherwise payable to me under the terms of my insurance. I authorize photocopies of this form to be as valid as the original.

Signature Date

I understand and agree that I am responsible for the payment of any charges which are incurred for the services provided by Nephrology, Inc. If I fail to pay any balance due in a timely fashion and it becomes necessary for Nephrology, Inc. to retain an attorney to assist in the collection of my account, I do hereby agree to be responsible for all reasonable attorney's fees incurred by Nephrology, Inc. All of the information which I have provided is true and accurate. I agree to notify Nephrology, Inc. of any changes in my health status or in any of the information listed herein.

Signature Date