PATIENT INFORMATION
PLEASE ANSWER ALL QUESTIONS

Patient Name: ____ Male: ___ Female: ___ Date of Birth: ____/____/____
Last First M.I.
Social Security #: ______________________ Marital Status: S M D W Spouse's Name: _________________________________

Primary Address: ____ Apt. #: ______ City: _________________________________
State: ____ Zip Code: ____ /____________
Home Phone #: (____) ______________ Cell Phone #: (___) ________________

Secondary Address: ____ Apt. #: ______ City: _________________________________
State/Zip Code: ____/ __________________
Home Phone #: (___) _______________ Cell Phone #: (____) _______________

Emergency Contact Name: ___________________________________ Relationship: ________________ Phone #: ________________

Race: ◻ White ◻ Black or African American ◻ Asian ◻ American Indian ◻ Hawaiian or Pacific Islander ◻ Other
Ethnicity: ◻ Hispanic or Latino ◻ Non-Hispanic or Latino
Preferred communications: ◻ Patient Portal ◻ Cell phone ◻ Home phone ◻ Work Phone
Preferred language: ◻ English ◻ Spanish ◻ Other

Employer Name: ____ Work phone: (____) _____________________

Nearest Relative Not Living with You: ____
Name Address Phone

Referring Physician: ____
Last Name First Name M.I.

Retail Pharmacy: _____________________________ City: ___________________ State: ____ Phone #: (____) __________________
Mail Order Pharmacy: ______________________________ Phone #: ____________________________

Known Drug Allergies: ____

INSURANCE INFORMATION

Primary Insurance: ____ Policy ID #: _________________________________
Address: ____ Group #: ____________________________________
Subscriber Name: _____________________________ DOB: ____ / ____ / ____ Social Security #: ____________________________
Subscriber Employer: ____

Secondary Insurance: ____ Policy ID #: _________________________________
Address: ____ Group #: ____________________________________
Subscriber Name: _____________________________ DOB: ____ / ____ / ____ Social Security #: ____________________________

ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION

For MEDICARE PATIENTS: I authorize the physicians and/or staff of South Palm Beach Nephrology, P.A. to release to the Social Security Administration, Health Care Financing Administration or its intermediaries or Insurance Carriers and/or the above named Medigap insurer any information needed for this or any Medicare and/or Medigap claim. I permit a copy of this authorization to be used in place of the original and request payment of medical information benefits either to myself or to the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply. I understand that signing this authorization may cause Medicare payment information to cross over automatically to my supplemental insurer. I understand that I am financially responsible for any services deemed non-covered by Medicare.

____ ____________
PATIENT OR LEGAL REPRESENTATIVE SIGNATURE Date

For PPO and HMO PATIENTS: I authorize the physicians and/or staff of South Palm Beach Nephrology, P.A. to release to my insurance company or its representatives any information including the diagnosis and records of any treatment or examination rendered to me during medical or surgical care. I authorize and request my above named insurance company to pay directly to South Palm Beach Nephrology, P.A. the amount due for medical or surgical services. I understand I am financially responsible for any services deemed non-covered by my insurance company.

____ ____________
PATIENT OR LEGAL REPRESENTATIVE SIGNATURE Date

For ALL OTHER PATIENTS: I understand that I am financially responsible for services rendered in this office.

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PATIENT OR LEGAL REPRESENTATIVE SIGNATURE Date