Nephrology Associates of the Gulf Coast
8333 North Davis Hwy, Pensacola, FL 32514

Voice : 850-474-8121
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Patient Registration Form

Last Name: _____ First Name: _____ MI: _____

Social Security Number: _____ Date of Birth: _____ Sex: M F

Address: _____ City: _____

State: _____ Zip: _____ **Marital Status**: Married Single Divorced Widowed

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown/Declined to answer

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American

☐ Native Hawaiian or Pacific Islander ☐ White ☐ Unknown/Declined to Answer

Home Phone: (____) _____ Cell Phone:(____) _____ Work Phone: (____) _____

Spouse's Name: _____ Spouse's Phone: _____

Referring Provider _____ How did you hear about us?_____

Emergency Contact

Last Name: _____ First Name: _____ MI: _____

Relationship: _____ Phone: _____

Next of Kin

Last Name: _____ First Name: _____ MI: _____

Relationship: _____ Phone: _____

Insurance Information

Primary Insurance Company: _____

Effective Date of Policy: _____ Group/Plan #: _____ Policy #: _____

Subscriber's Name: _____ DOB: _____ Relation to Patient:_____

Subscriber's Social Security #: _____ Employer: _____

Secondary Insurance Company: _____

Effective Date of Policy: _____ Group/Plan #: _____ Policy #: _____

Subscriber's Name: _____ DOB: _____ Relation to Patient:_____

Subscriber's Social Security #: _____ Employer: _____

Disclosure to Families and Designated Individuals

I authorize Nephrology Associates of The Gulf Coast, to disclose my healthcare information and discuss my healthcare needs to those that I designate. If I do not provide authorization, no information can be shared. I authorize Nephrology Associates of The Gulf Coast to disclose my personal health information to the following people:

_____ Phone: (____) _____
Name / Relationship

_____ Phone: (____) _____
Name / Relationship

_____ Phone: (____) _____
Name / Relationship

Consent to Treatment

I hereby grant authorization and consent for medical treatment for myself or the patient for whom I am the guardian or legally authorized representative for which I am signing for, and understand that no guarantee or assurance has been made as to the results for which may be obtained. I agree to allow my provider to access all my medication history including medications prescribed by other providers.

_____
Patient Initials

Photo Documentation

I hereby grant authorization for Nephrology Associates of The Gulf Coast (NAGC) to make a copy of my photo identification to be included in my Electronic Health Record (EHR) as well as take a digital picture for additional protection against the theft of my medical identity.

_____
Patient Initials

Insurance Assignment and Financial Responsibility

I certify that the above information is correct to the best of my knowledge. I hereby authorize NAGC, to release any medical information required during the course of examination and treatment to my insurance company, and I permit payment to NAGC from my insurance for any benefits due any services rendered. I recognize and accept responsibility for services rendered regardless of insurance coverage. This includes but is not limited to coinsurance, copayment, deductibles and non-covered services

I understand that I am responsible for all charges incurred regardless of the insurance status. I also agree to pay my bill in full for services rendered by Nephrology Associates of The Gulf Coast (NAGC).

_____ _____
Signature of Patient Date

_____
Print Name