

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: (____) _____
Occupation: _____
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:

Name / Relationship Phone: (____) _____

Name / Relationship Phone: (____) _____

Name / Relationship Phone: (____) _____

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