RENAL PHYSICIANS, INC

PLEASE PRINT

PATIENT INFORMATION

Name: Last First Mi

Street City State Zip

Social Security# Date Of Birth Age Sex

Home# Cell# Work#

Email Address

Patient's Employer Employer's Address

Spouse's Name SSI# D.O.B

Spouse's Employer Phone#

Primary Care (Family) Doctor Pharmacy Name

Can message be left? Yes No If so, at what number? Cell Home Work

EMERGENCY CONTACT

Name Address

Phone#

INSURANCE INFORMATION

Primary: Name Subscriber D.O.B

Address Phone

Policy# Group# Eff Date

Secondary: Name Subscriber D.O.B

Address Phone

Policy# Group# Eff Date

Responsible Party: (if other than patient)

Name: Last First Mi Phone#

Address City State ZIP

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any balance not paid for by your insurance.

PLEASE READ AND SIGN THE FOLLOWING:

I directly assign title to all medical/surgical benefits to **Renal Physicians, Inc** and understand that I am financially responsible for all charges whether or not paid by the insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original. This signature indicates consent for treatment by Renal Physicians, Inc.

Sign here _____ Date _____

Rev: 5/16/14