Patient information Form

Date: _____

Last Name _____ First Name _____ MI _____

Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Work Phone _____

Cell Phone _____ Email _____

Social Security Number _____ Date of Birth _____

Sex: M F (circle one) Marital Status: S M D W (circle one)

Spouse's Name _____

Spouse's Social Security Number _____

Spouse's Date of Birth _____

PATIENT EMPLOYER INFORMATION

Current Status: Employed Retired Disabled Student Other (circle one)

Employer Name _____

Address _____

City _____ State _____ Zip Code _____

EMERGENCY CONTACTS

Name Relationship Phone Number

_____

_____

_____

HEALTH CARE CONTACT INFORMATION

Primary Care Physician _____ Phone _____

Referring Physician _____ Phone _____

Cardiologist _____ Phone _____

Pharmacy Name _____ Phone _____

Nursing Home Name _____ Phone _____

POLICY HOLDER INFORMATION (If other than patient)

Last Name _____ First Name _____ MI _____

Address _____

City _____ State_____ Zip Code _____

Social Security Number _____ Date of Birth _____

Home Phone _____ Work Phone _____

Cell Phone _____ Marital Status: S M D W (circle one)

Employer's Name _____

Address _____

City _____ State _____ Zip Code _____

INSURANCE INFORMATION

Primary Insurance Name _____

Identification Number _____

Group/Policy Number _____

Address _____ City _____

State _____ Zip Code _____ Phone Number _____

INSURANCE INFORMATION CONTINUED

Secondary Insurance Name _____

Identification Number _____

Group/Policy Number _____

Address _____ City _____

State _____ Zip Code _____ Phone Number _____

Authorization to Release Information

I hereby authorize Kidney Care of Michiana, LLC. to release all information acquired in the course of my examination and/or treatment to process insurance claims.

Authorization to Pay Benefits

I hereby authorize payments to Kidney Care of Michiana, LLC. of the medical benefits, if any, otherwise payable to me under the terms of my insurance. Photo copies of this form shall be as valid as the original.

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

Patient Signature: _____

Date: _____