

COLUMBIA NEPHROLOGY ASSOCIATES, P.A.
PATIENT INFORMATION

Chart # _____

Patient Name: _____ DOB: ____/____/____ SSN: _____

Address: _____ Apt _____ City, State, Zip _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Sex: M F Marital Status: M S W D (Circle One)

Employer's Name: _____ Address: _____

Were you referred by a doctor? Y N (Circle One) If yes, Doctor's name _____

Who is your Primary Care Physician? _____

INSURANCE INFORMATION

Please fill out completely. Be sure we copy your insurance cards.

Primary Insurance: _____ **Phone:** _____

Policy Holder Name: _____ **SSN:** _____

Date of Birth: ____/____/____ **Relation to Patient:** _____ **Policy Number:** _____

Employer Name: _____

Secondary Insurance: _____ **Phone:** _____

Policy Holder Name: _____ **SSN:** _____

Date of Birth: ____/____/____ **Relation to Patient:** _____ **Policy Number:** _____

Employer Name: _____

Emergency Contact: _____ **Home:** _____ **Work:** _____ **Cell:** _____

I hereby authorize the release of any medical or other information necessary to process insurance claims. I also authorize payment of medical benefits directly to the practice for the services rendered.

Signature: _____

Date: ____/____/____