

ACCT# _____

PATIENT INFORMATION FORM

Patient Name _____ Age _____ Date of Birth _____

Address _____ Home Telephone _____

_____ Work Telephone _____

City, _____ State _____ Zip Code _____

Gender: Male / Female SSN _____ Single Married Widowed Divorced

Occupation _____ Drug Allergies _____

Work Address _____ Employer _____

Responsible Party (If not the patient) _____

Address _____ Relationship _____ Employer _____

INSURANCE COVERAGE

Medicare _____ Medicaid _____

HMO/PPO _____ Referral # _____

Other Insurance _____ Group # _____ Policy # _____

Address _____ Name of Group _____

Insured _____ Insured D.O.B. _____

Who referred you to us? Doctor Friend Medical Society Other _____

Name of your Physician _____ Phone Number _____

Address of your Physician _____

Who should we notify in case of an emergency? _____ Relationship _____

Address _____ Phone Number _____

PLEASE NOTIFY US IF ANY OF THE ABOVE INFORMATION CHANGES WHILE YOU ARE A PATIENT OF OURS. YOUR TELEPHONE NUMBER AND ADDRESS ARE ESPECIALLY IMPORTANT.

ASSIGNMENT AND RELEASE OF INFORMATION

I hereby transfer and assign San Antonio Kidney Disease Center Physicians Group, P.L.L.C. to release any information acquired in the course of my examination and treatment to my insurance carrier(s). I release the group and all its providers from all legal responsibility or liability that may arise from the act I have assigned.

ASSIGNMENT FOR PAYMENT OF INSURANCE BENEFITS

I hereby transfer and assign payment of medical benefits directly to the San Antonio Kidney Disease Center Physicians Group, P.L.L.C. and/or any and all of its providers.

Signature

Date

Relationship to Patient