Carolina Kidney Care

Patient Registration Information

Patient's Name (Last, First, MI): _____

Sex: ____M ____F Patient's DOB: _____/_____/_____ Age: _____ SSN: _____-_____-_____

Address: _____

Billing Address (If different from above): _____

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

Preferred Number for Contact: _____ Preferred Language (Please bring Interpreter): _____

Email Address: _____ Marital Status: _____ Disabled: ___ Yes ___ No

Patient's Employer: _____ Occupation: _____

Ethnicity & Race (Please Check One): ___ Hispanic/Latino ___ Caucasian/White ___ African American/Black ___ Native American

___ Native/Alaskan ___ Asian ___ Native Hawaiian ___ Other:_____

Spouse's Name: _____ Preferred Number: _____ SSN: _____-_____-_____

Emergency Contact: _____ Relationship: _____ Phone Number: _____

Emergency Contact's Address: _____

What office referred you to us? _____ Primary Care Doctor: _____

Primary Policy Holder's Name: _____ DOB: _____ Sex: _____

Employer: _____ Phone Number: _____

Insurance Company: _____ Policy and/or Group #: _____ Relationship to Patient: _____

Secondary Policy Holder's Name: _____ DOB: _____ Sex: _____

Employer: _____ Phone Number: _____

Insurance Company: _____ Policy and/or Group #: _____ Relationship to Patient: _____

****SELF PAY PATIENTS****

Self-Pay Patients are requested to pay a deposit of $25.00 prior to being seen.

Date: _____ Signature: _____

MEDICARE INFORMATION

Statement to permit Medicare Payment to Provider

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or future Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment to me.

Date: _____ Signature: _____

ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION

I hereby authorize payment of the Surgical and/or Medical Benefits, if any, otherwise payable to me, direction to the Physician for his services as described. I realize that I am responsible for payment for non-covered services. I also authorize the Physician to release any information acquired during the course of my treatment that is necessary to process insurance claims.

Date: _____ Signature: _____