Patient ID #:

Associates In Nephrology

Patient Information Verification

Please provide and/or review the following information for accuracy. If any of this information has changed, make the appropriate corrections on this form.

SSN: _____

Last Name: _____

First Name: _____

Middle Name: _____

Home Address: _____

_____

Home Phone: _____

Cell Phone: _____

E-mail: _____

Can we send result/correspondence emails: ☐ Yes ☐ No

Sex: ☐ Male ☐ Female

Marital Status: _____

Date of Birth: _____ (mm/dd/yyyy)

Employer: _____

Employment Status: _____

Work Phone: _____ Ext.

Emergency Contact: _____

Relationship: _____

Contact Phone: _____ Ext.

Race: _____

Ethnicity(Hispanic/Latino): ☐ Yes ☐ No

Preferred Language: _____

Primary Insurance

Insurance: _____

Policy Number: _____

Group Number: _____

Effective Date: _____ (mm/dd/yyyy)

Expiration Date: _____

Copay: _____

Comments: _____

_____

Secondary Insurance

Insurance: _____

Policy Number: _____

Group Number: _____

Effective Date: _____ (mm/dd/yyyy)

Expiration Date: _____

Copay: _____

Comments: _____

_____

Whom can we share information with:

_____

☐ **Patient Verified** _____ (Signed) Dated: _____

☐ **Entered in System (for official use)** _____ (Initials) Dated: _____

Patient Assignment of Benefits:

Patient Health Information:

Receipt of Privacy Notice:

Statement of Financial Responsibility:

Last Insurance Verification: