PATIENT REGISTRATION

Full Name ____

Birth Date _________________________ Social Security # __________________

Local Address ____

City ________________________________ Zip Code _____________

Name of Employer ____

Telephone numbers (needed for immediate contact by doctor; therefore, we require at least 2 numbers where you may be reached)

Employer's #:

Home: _________________________ Business (daytime) _________________________

Cell: ___________________________

Marital Status: M S W D

Spouse's Name _________________________ Spouse's work # _________________

In case of emergency notify (who does not reside with you):

____

Relationship ______________________________ Telephone ______________________

Primary Physician ____

Reason for this visit ____

Name of referring physician ____

How did you hear about our practice ______________________________________

INSURANCE AUTHORIZATION

I authorize medical information released to the Social Security Administration, the Health Care Financing Administration and/or my insurance carrier as needed for this or related claims. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits to the Fort Lauderdale Renal Group. Regulations pertaining to Medicare assignment of benefits apply. Sign, print and bring to the office (email to Kidneygroup@aol.com)

Signature ________________________________ Date