TAMPA BAY NEPHROLOGY ASSOCIATES, PL

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PATIENT REGISTRATION (please print)

Patient's Name: ______________________________________ **Birthdate:**________________________
Address: ____
City____**State**________________**Zip**_________________
Phone: (______)________________________________ **Social Security#:** ________________________
Gender: Male_________ **Female**________ **Marital Status: Single / Married / Divorced / Widowed**
Cell Phone: (____)______________________ **Email Address:**____________________________________

Can we text you for appt reminders? Yes / No ***Can we email you appt reminders? Yes / No***

Pt's Employer's Name (If Applicable) ____________________________ **Occupation:**_____________
Address/City/State/Zip: _________________________________**Home Phone: (____)**______________

Primary Care Physician (PCP):____
PCP Phone: (_____)________________ **PCP Fax: (____)**____________________________________
Referred By: _______________________ **Ph: (_______)**_______________**Fax: (_____)**_____________

Spouse's/Guardian's Name:______________________________ **Ph#: (____)**______________________
Or Name Of Parent/Guardian:____
Address, City, State, Zip:____

Emergency Contact Name: _____________________________________***Ph#:(____)***_________________
Relationship To Patient:____
Address, City, State, Zip:____

Patient's Primary Insurance ***(Medicare, or Private Insurance Company):***
Name:__________________________________**Subscriber ID #:**______________________________
Phone: (_______)________________________ **Group #:** ____________________________________
Name of Insured, (If Other Than Patient): ____

Patient's Secondary Insurance:
Name: _________________________________ **Subscriber #:** __________________________________
Phone: (_______)_______________________ **Group #:** _____________________________________

Pharmacy Information:
Name of Pharmacy: ______________________**Ph#: (____)**_________ **Fax#: (____)**______________

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION – **I agree and understand the following:**
(1) The insurance policy is a contract between my insurance company and me; (2) I request that payment of authorized benefits be made to the above named doctor(s) office on my behalf, for any services provided to me and it is my responsibility to notify this office of any insurance changes at the time of the visit or I will be responsible for those costs due to my error of omission; (3) I agree to pay for all charges incurred whether or not paid by the above stated insurance; (4) I authorize and direct payment to Tampa Bay Nephrology Associates, PL for the benefits, if any, payable to me under the terms of my insurance company; (5) I may be charged 1.5% interest rate per month on any unpaid balance and I am responsible for any costs incurred in collection of balance; (6) I authorize any holder of medical and other information about me to be released to Health Care Financing Administration, Medicare, its agents, insurance company, any third party payer, state medical assistance agency, any other governmental or private payer responsible for paying such benefits, and any information needed to determine these benefits or benefits for related services. **By signing this form I also authorize that:** (1) my email and cell phone information can be used as a form of communication (if indicated above), (2) a copy of this form can be used in place of the original, (3) I have received a copy or have access to the Tampa Bay Nephrology Associates' Notice of Privacy Practice, describing how my health information is used and shared, (4) I will notify the office to reschedule an appointment within 24 hours or I will be charged $25.00. I have read and understand the above and agree to comply. ***This form is valid for 1 year.***

____ ______________________________

Patient Signature **Date**