

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.

Signature _____ Date _____