CAPITAL NEPHROLOGY

Patient's Information

Name: _____ Date _____

Address: _____ SS#: _____

City: _____ State _____ Zip_____ Height: ___'___" Weight _____

Reason for Visit: _____ **M** ____ **F**____

Contact Phone: (____) _____ Cell Phone: (_____)_____ Work (____)_____

Date of Birth : _____ Ref by: _____ Race: _____

E-mail address_____

Occupation: _____ Employer: _____ Work: (____)_____

If under 18: Parent/Guardian_____

Emergency Contact Information:

Name: _____Address: _____

Relationship: _____Phone :(____) _____

Billing Information

Responsible Person other than patient: _____Relationship _____

Billing Address:_____Phone: (____)_____

INSURANCE INFORMATION

Primary

Insurance Company: _____

Name of Insured if other than Patient: _____Relation: _____

Identification Number: _____ Group Number:_____

Secondary:

Insurance Company: _____

Name of Insured if other than Patient: _____Relation: _____

Identification Number:_____ Group Number:_____

Assignment of Insurance Benefits - Medicare - Medicaid

I hereby authorize direct payment of medical/surgical benefits to Promod Duggal, MD, for services rendered by him in person or under his supervision. I understand that I am financially responsible for any balance not covered by my insurance carrier.

Authorization to release information

I hereby authorize Promod Duggal, MD to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefit.

A photocopy of these assignments shall be valid as the original.

Patient Name: _____ Date: _____

Parent / Guardian_____

Signature: _____