DIALYSIS ASSOCIATES, P.C.

PATIENT REGISTRATION FORM
(PLEASE FILL OUT **COMPLETELY, PRINT AND SIGN**)

PATIENT INFORMATION SECTION

PATIENT NAME (LEGAL):_____

PATIENT ADDRESS:_____

CITY:_____ **STATE:**_____ **ZIP:**_____

PATIENT HOME PHONE:(_____)_____

PATIENT BIRTHDATE:_____**MALE**_____**FEMALE**_____

PATIENT SOCIAL SECURITY NUMBER:_____

MARITAL STATUS: M( ) S( ) W( ) D( )

NEXT OF KIN NAME:_____
(EMERGENCY)

NEXT OF KIN PHONE NUMBER:(_____)_____
(EMERGENCY) **OTHER THAN YOUR HOME; FOR AUDIT PURPOSES**

NAME OF FAMILY PHYSICIAN:_____
(PRIMARY PHYSICIAN)

FAMILY (PRIMARY) PHYSICIAN PHONE NUMBER: (_____)_____

NAME OF REFERRING PHYSICIAN:_____

REFERRING PHYSICIAN PHONE NUMBER:(_____)_____
****
IS PATIENT A RESIDENT OF A NURSING FACILITY? _____YES _____ NO

IF PATIENT IS A RESIDENT OF A NURSING FACILITY, PLEASE PROVIDE THE FOLLOWING INFORMATION:

NAME OF FACILITY:_____

ADDRESS OF FACILITY:_____

CITY:_____ **STATE:**_____ **ZIP:**_____

PHONE NUMBER OF FACILITY: (_____)_____

EMPLOYMENT AND INSURANCE INFORMATION

PATIENT EMPLOYER: _____

EMPLOYER ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

EMPLOYER PHONE NUMBER: (_____)_____

FULL TIME? _____ **YES** _____ **NO**

ARE YOU SELF-EMPLOYED? _____ **YES** _____ **NO**

IS PLACE OF EMPLOYMENT CONSIDERED A LARGE GROUP (100 OR MORE EMPLOYEES)? _____ **YES** _____ **NO**

IS PLACE OF EMPLOYMENT CONSIDERED A SMALL GROUP (LESS THAN 100 EMPLOYEES)? _____ **YES** _____ **NO**

DOES PATIENT HAVE INSURANCE COVERAGE THROUGH THIS EMPLOYER?
_____**YES** _____ **NO**
(PLEASE PROVIDE A COPY OF INSURANCE CARD)

****

DOES PATIENT HAVE PRESCRIPTION COVERAGE? _____ **YES** _____ **NO;**

IF YES, IS THIS "MEDICARE PART D"? _____ **YES** _____ **NO; IF YES,**

PLEASE PROVIDE COPY OF MEDICARE PART D CARD.

****

IS PATIENT RETIRED? _____ **YES (IF SO, WHAT YEAR** _____**);** _____ **NO**

DOES PATIENT HAVE MEDICARE? _____ **YES** _____ **NO**
IF "YES", WHY DID PATIENT QUALIFY FOR MEDICARE?
_____ **AGE** _____ **DISABILITY**

IF "DISABILITY", WHAT IS DISABILITY DUE TO? (PLEASE EXPLAIN WHAT MEDICAL CONDITION CAUSED THE DISABILITY) _____

_____

_____

WHAT IS THE PRIMARY INSURANCE COVERAGE FOR PATIENT?

NAME OF INSURANCE: _____

NAME OF INSURED: _____

INSURED'S SOCIAL SECURITY NUMBER: _____

INSURED'S BIRTH DATE: _____

INSURED'S RELATIONSHIP TO PATIENT: ____SPOUSE; ____SELF; _____ DEPENDENT

****

DOES PATIENT HAVE A SECONDARY INSURANCE COVERAGE? ____ YES, _____ NO

IF "YES", PLEASE PROVIDE THE FOLLOWING INFORMATION:

A COPY OF INSURANCE CARD

NAME OF INSURANCE: _____

NAME OF INSURED: _____

INSURED'S SOCIAL SECURITY NUMBER: _____

INSURED'S BIRTH DATE: _____

INSURED'S RELATIONSHIP TO PATIENT: ____ SPOUSE; ____ SELF; _____ DEPENDENT

****

DOES PATIENT HAVE A THIRD INSURANCE COVERAGE? _____ YES, _____ NO

IF "YES" PLEASE PROVIDE THE FOLLOWING INFORMATION:

A COPY OF INSURANCE CARD

NAME OF INSURANCE: _____

NAME OF INSURED: _____

INSURED'S SOCIAL SECURITY NUMBER: _____

INSURED'S BIRTH DATE: _____

INSURED'S RELATIONSHIP TO PATIENT: _____SPOUSE; _____SELF; _____ DEPENDENT

IN ORDER TO SUBMIT A CLAIM FOR PAYMENT TO THIS OFFICE FOR SERVICES COVERED UNDER YOUR POLICY, WE MUST HAVE YOUR WRITTEN AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO YOUR INSURANCE CARRIER(S).
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MEDICARE

PATIENT'S CERTIFICATION, AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST.

"I CERTIFY THAT THE INFORMATION GIVEN BY ME IN APPLYING FOR PAYMENT UNDER TITLE XVIII OF THE SOCIAL SECURITY ACT IS CORRECT. I AUTHORIZE ANY HOLDER OF MEDICAL OR OTHER INFORMATION ABOUT ME TO RELEASE TO THE SOCIAL SECURITY ADMINISTRATION OR ITS INTERMEDIARIES OR CARRIERS ANY INFORMATION NEEDED FOR THIS OR A RELATED MEDICARE CLAIM. I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL AND REQUEST THAT PAYMENT OF AUTHORIZED BENEFITS BE MADE ON MY BEHALF."
"I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY HEALTH INSURANCE DEDUCTIBLE AND/OR CO-INSURANCE."

PATIENT SIGNATURE:_____

DATE OF SIGNATURE:_____

****

ALL OTHER INSURANCES

"I HEREBY AUTHORIZE RELEASE OF INFORMATION NECESSARY TO FILE A CLAIM WITH MY INSURANCE COMPANY AND ASSIGN BENEFITS OTHERWISE PAYABLE TO ME TO THE DOCTOR INDICATED ON THE CLAIM. I UNDERSTAND I AM FINANCIALLY RESPONSIBLE FOR ANY BALANCE NOT COVERED BY MY INSURANCE CARRIER. A COPY OF THIS SIGNATURE IS AS VALID AS THE ORIGINAL."

PATIENT SIGNATURE:_____

DATE OF SIGNATURE:_____