NORTH CAROLINA NEPHROLOGY, P.A.

1-877-NCN-NCN9 (1-877-626-6269)

NEW PATIENT PROFILE

PATIENT NAME: _____ Date of Birth: _____
First MI Last

Sex: □ Male □ Female □ Undefined Soc Sec #: _____

Preferred Language: _____ Race: _____

Ethnicity: □ Not Hispanic or Latino □ Hispanic or Latino □ Patient Declined

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ (preferred) □ Home □ Mobile □ Work

_____ (alternate) □ Home □ Mobile □ Work

Email: _____

Emergency Contact: _____ Phone #: _____

Emergency Contact Relationship to Patient: _____

Employed: □ Yes □ No Patient's Employer: _____

Employer Address: _____ Work #: _____

Referring Physician: _____

Primary Care: _____

GUARANTOR INFORMATION: □ Same as Patient (skip this section)

Guarantor's Name: _____ Date of Birth: _____
First MI Last

Sex: □ Male □ Female □ Undefined Patient's Relationship to Guarantor: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ (preferred) □ Home □ Mobile □ Work

_____ (alternate) □ Home □ Mobile □ Work

Email: _____

INSURANCE INFORMATION: PRIMARY Patient's Name: _____

Insured Person Information: □ Same as Patient (complete Insurance Carrier/Policy #/Group #)

Insurance Company: _____

ID #: _____ Group #: _____

IF POLICY HOLDER IS DIFFERENT FROM PATIENT:

Insured Person Info: _____ Date of Birth: _____
First MI Last

Sex: □ Male □ Female □ Undefined Soc Sec #: _____

Office Use ONLY

Date Verified: _____ Verified by: _____

Effective Date: _____

INSURANCE INFORMATION: SECONDARY

Insured Person Information: □ Same as Patient (complete Insurance Carrier/Policy #/Group #)

Insurance Company: _____

ID #: _____ Group #: _____

IF POLICY HOLDER IS DIFFERENT FROM PATIENT:

Insured Person Info: _____ Date of Birth: _____
First MI Last

Sex: □ Male □ Female □ Undefined Soc Sec #: _____

Office Use ONLY

Date Verified: _____ Verified by: _____

Effective Date: _____

I authorize North Carolina Nephrology, P.A., to file claims to my insurance company on my behalf for services rendered by providers of North Carolina Nephrology, P.A.

Patient Signature: _____ Date: _____