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: ______________________________

Insurance: Please bring your insurance cards to your visit and complete the information below.

Do you have an insurance that requires Prior Authorization (Veterans, Tricare, HMO, etc)? Please ensure this is obtained prior to your visit. Without it, incurred charges are the patient's responsibility.

Guarantor: ______________________________
Name DOB Relationship to pt

Primary Insurance

____
Insurance Company ID # Group #

Policy Holder Info if different from patient: __________
Name DOB

Secondary Insurance

____
Insurance Company ID # Group #

Policy Holder Info if different from patient: __________
Name DOB