**Nephrology Associates of Kentuckiana, PSC 502.587.9660 Office 502.540.5615 Fax Pt #_____**
**Dr _____**

***Patient Name*** _____ ***Birth Date***_____ ***Patient Sex*** _____

***Race*** _____ ***Primary Language Used*** _____

***Patient SS#***_____ ***Patient Marital Status***_____

***Patient Address***_____ ***City*** _____ ***State***_____ ***Zip*** _____

***Home Phone*** _____ ***Cell*** _____ ***Work*** _____

***Emergency Contact***___ _____ ***Phone*** _____ ***Relationship*** _____

***PRIMARY CARE (FAMILY) DOCTOR*** _____ ***Phone Number*** **(  )** _____

***Referring Physician Name*** _____ ***Phone Number*** **(  )** _____

**PHARMACY NAME/LOCATION**

***INSURANCE Company*** **#1** _____ **EMPLOYER**_____

**ID Number** _____ **Group Number** _____

**Policy Holder's Name**_____ **DOB** _____**Gender** _____

**Policy Holder's RELATIONSHIP to the *PATIENT*:**

***INSURANCE Company*** **#2** _____ **EMPLOYER**_____

**ID Number** _____ **Group Number** _____

**Policy Holder's Name**_____ **DOB**_____ **Gender** _____

**Policy Holder's RELATIONSHIP to the *PATIENT:***

***ADDITIONAL INFORMATION TO ENSURE CORRECT CLAIM FILING -PLEASE COMPLETE ALL-***

**Are *YOU* currently employed? □Yes/No If yes, Over 20 employees □Yes/□ No; Over 100 □ Yes/□ No**
**EMPLOYER :** _____

**Is your *SPOUSE* currently employed?□Yes/□No If yes,over 20 employees □Yes/□ No;Over 100 □Yes/□No**
**EMPLOYER :** _____

**Are *YOU* retired? □Yes/□No If yes, Retirement date_____Company_____**
**Is your *SPOUSE* retired? □Yes/□No If yes, Retirement date_____Company_____**

**Are *YOU* disabled? □Yes/□No If yes, Disability Month_____Year_____**
**Is your *SPOUSE* disabled? □Yes/□No If yes, Disability Month _____Year_____**

**AUTHORIZATIONS: PATIENT, PLEASE SIGN AND DATE.**
**FOR PRIVATE INSURANCE PATIENTS:**
**I authorize Nephrology Associates of Kentuckiana, PSC to release any information regarding services rendered to me and allow a photocopy of my signature to be used to file insurance. I also authorize my insurer to issue payment for benefits due me for the services rendered to me directly to Nephrology Associates of Kentuckiana, PSC. I understand that, regardless of insurance benefits, I am financially responsible for the fees for services rendered.**
**FOR MEDICARE PATIENTS:**
**I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize my 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 request the payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the service or authorize such physician or organization to submit a claim to Medicare for payment to me.**

_____ _____