SOUTH SHORE NEPHROLOGY

PATIENT REGISTRATION FORM

Visit us at http://www.southshorenephrology.com

PATIENT DEMOGRAPHIC INFORMATION

Patient Name _____ PCP _____
First MI Last

Cell Phone: _____

SSN _____ ❍ Male ❍ Female Birthdate ____/____/ _____ Home Phone: _____

Address _____ City _____ State _____ Zip _____

Check appropriate box: ❍ Minor ❍ Single ❍ Married ❍ Separated ❍ Divorced ❍ Widowed

Employment Status: ❍ Full-Time ❍ Part-Time ❍ Self-Employed ❍ Retired ❍ Student ❍ Child ❍ Unemployed ❍ Other

Patient's or Parent's Employer _____ Work Phone _____

Patient's Email _____ Would you like access to the SSN Patient Portal? ❍ Yes ❍ No

Which best describes your race? ❍ White ❍ Black / African American ❍ Hispanic ❍ American Indian / Alaska Native
❍ Asian ❍ Native Hawaiian or other Pacific Islander ❍ Other ❍ Informed Refusal

Which best describes your ethnicity? ❍ Non-Hispanic or Latino ❍ Hispanic or Latino ❍ Other ❍ Informed Refusal

Do you have a language preference? ❍ English ❍ Am. Sign Language ❍ French ❍ Portuguese ❍ Spanish ❍ Other _____

EMERGENCY CONTACT / PHARMACY INFORMATION

Person to contact in case of emergency _____ Relationship _____ Phone _____

Pharmacy _____ Pharmacy Phone _____

Mail Away Pharmacy _____ Mail Away Phone _____

SPOUSE / RESPONSIBLE PARTY INFORMATION

Name of person responsible for this account _____ Relationship to patient _____

Address _____ Home Phone _____

SSN _____ Birthdate ____/____/_____ Cell Phone _____

INSURANCE INFORMATION

*** PLEASE PROVIDE YOUR INSURANCE CARD TO THE RECEPTIONIST ***

❍ Commercial ❍ Medicaid ❍ Medicare ❍ Workers' Comp. ❍ Other

Insurance carrier name _____ Policy Number _____

Insured card holder's name _____ Relationship _____ Group number _____

Phone number of insurance carrier _____ How much is your co-payment? _____

SECONDARY INSURANCE INFORMATION

*** PLEASE PROVIDE YOUR INSURANCE CARD TO THE RECEPTIONIST ***

Insurance carrier name _____ Policy Number _____

Insured card holder's name _____ Relationship _____ Group number _____

Phone number of insurance carrier _____ How much is your co-payment? _____

AUTHORIZATION

I authorize South Shore Nephrology, PC to perform diagnostic tests and procedures and to undertake such treatment as deemed necessary or advisable in the care of myself or the above named person. I authorize release of any and all medical information necessary to process my insurance claims. I assign all benefits from named insurers to be paid to South Shore Nephrology, PC whether on an assigned or unassigned basis. I understand that I am fully responsible for co-pays, deductibles, balances on approved charges and for charges considered non-covered by my insurance carrier.

_____
SIGNATURE *(Patient or Parent if minor)*

_____/_____/_____
DATE

R/03/29/17