Durham Nephrology Associates, P.A.

PATIENT REGISTRATION FORM (Please PRINT clearly)

PATIENT INFORMATION

Last Name	First Name	M.I.	Nickname

Date of Birth	Social Security Number	Gender

Mailing Address	City	State	Zip

Home Phone	Cell Phone	Work Phone

Employment Status	Employer/School

Marital Status	Race (Optional)

Primary Care Provider	Your email

RESPONSIBLE PARTY (GUARANTOR OR SUBSCRIBER) INFORMATION

Relationship to Patient ☐ Self (If self, skip to Emergency / Next of Kin) ☐ Spouse ☐ Parent/Guardian ☐ Other

Last Name	First Name	Middle Initial

Date of Birth	Social Security Number	Gender

Mailing Address	City	State	Zip

Home Phone	Cell Phone	Work Phone

Employment Status	Employer

INSURANCE INFORMATION

Primary Insurance Company

Insurance/Policy No	Group No.	Effective Date
Subscriber Name	**Subscriber Birthdate**	**Subscriber Social Security No.**

Relationship to Patient ☐ Self ☐ Spouse ☐ Parent/Guardian ☐ Other

Secondary Insurance Company

Insurance/Policy No	Group No.	Effective Date
Subscriber Name	**Subscriber Birthdate**	**Subscriber Social Security No.**

Relationship to Patient ☐ Self ☐ Spouse ☐ Parent/Guardian ☐ Other

Other Insurance Company

Insurance/Policy No	Group No.	Effective Date
Subscriber Name	**Subscriber Birthdate**	**Subscriber Social Security No.**

Relationship to Patient ☐ Self ☐ Spouse ☐ Parent/Guardian ☐ Other