Durham Nephrology Associates, pa

PATIENT REGISTRATION FORM

PLEASE PRINT CLEARLY

PATIENT INFORMATION

LAST Name _____ **FIRST** Name _____

Middle Initial _____ Nickname _____

Date of Birth _____ /_____ /_____ SSN _____ - _____ - _____ Gender _____

Mailing Address _____ City _____ State _____ Zip _____

HOME Phone (_____) _____ - _____ CELL Phone (_____) _____ - _____

Email Address _____

Employment Status _____ Employer / School _____

Marital Status _____ Race (Optional) _____

Primary Care Provider _____

Pharmacy Address _____

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 _____ /_____ /_____ SSN _____ - _____ - _____ Gender _____

Mailing Address _____ City _____ State _____ Zip _____

HOME Phone (_____) _____ - _____ CELL Phone (_____) _____ - _____ WORK Phone (_____) _____ - _____

Employment Status _____ Employer _____

INSURANCE INFORMATION

PRIMARY Insurance Company _____

Insurance / Policy Number _____ Group Number _____ Effective Date _____

Subscriber Name _____ Birthdate _____ /_____ /_____ SSN _____ - _____ - _____

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

SECONDARY Insurance Company _____

Insurance / Policy Number _____ Group Number _____ Effective Date _____

Subscriber Name _____ Birthdate _____ /_____ /_____ SSN _____ - _____ - _____

EMERGENCY CONTACT INFORMATION

Name _____ Relationship to Patient _____

Contact Number (_____) _____ - _____

Name _____ Relationship to Patient _____

Contact Number (_____) _____ - _____