NEPHROLOGY ASSOCIATES OF N. VIRGINIA

PATIENT REGISTRATION INFORMATION

Date ______________ Soc. Sec. # ______________ Birthdate ______________

Name ______________ (Last Name, First Name, Initial) Home Phone ______________

Address ______________ Cell Phone ______________

City ______________ State ______ Zip ______ E-mail ______________

Sex: ❑ M ❑ F ❑ Minor ❑ Single ❑ Married ❑ Long Term Partner ❑ Divorced ❑ Widowed ❑ Separated

Employer ______________ Business Phone ______________

Business Address ______________ Occupation ______________

Who should we thank for referring you? ______________

In case of emergency, who should we contact? ______________ Phone ______________

PRIMARY INSURANCE

Person Responsible for Account ______________ (Last Name, First Name, Initial)

Relationship to Patient ______________ Birthdate ______________ Soc. Sec. # ______________

Address ______________ Home Phone ______________

City ______________ State ______ Zip ______

Responsible Party Employed By ______________ Business Phone ______________

Business Address ______________ Occupation ______________

Insurance Company ______________

Insurance Company Address ______________

Subscriber I.D. # ______________ Group # ______________

ADDITIONAL INSURANCE (IF APPLICABLE)

Insured Name ______________ (Last Name, First Name, Initial)

Relationship to Patient ______________ Birthdate ______________ Soc. Sec. # ______________

Address ______________ Home Phone ______________

City ______________ State ______ Zip ______

Insured Employed By ______________ Business Phone ______________

Insurance Company ______________

Insurance Company Address ______________

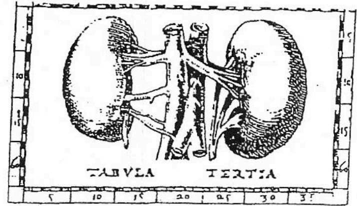
Subscriber I.D. # ______________ Group # ______________

ASSIGNMENT AND RELEASE

I hereby authorize payment directly to ______________ for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.

I authorize the above doctor and/or any provider or supplier of services in this office to release any information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party ______________ Date ______________



NEPHROLOGY ASSOCIATES OF NORTHERN VIRGINIA, INC
REFERRING PHYSICIAN INFORMATION

PATIENTS NAME

PHYSICIAN NAME: ______________________________

ADDRESS: ______________________________

____

PHONE: ____________________ FAX: ____________________

ADDITIONAL PHYSICIANS INVOLVED IN PATIENT'S CARE

PHYSICIAN NAME: ______________________________

ADDRESS: ______________________________

____

PHONE: ____________________ FAX: ____________________

PHYSICIAN NAME: ______________________________

ADDRESS: ______________________________

____

PHONE: ____________________ FAX: ____________________

PHYSICIAN NAME: ______________________________

ADDRESS: ______________________________

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PHONE: ____________________ FAX: ____________________

PHYSICIAN NAME: ______________________________

ADDRESS: ______________________________

____

PHONE: ____________________ FAX: ____________________

Nephrology Associates
of Northern Virginia, Inc.

ALL ALLERGY ALERTS

MEDICATION LOG

Patient Name: ______________________________ Birthdate: ______________

Home Phone: ______________________________ Pharmacy Phone: ______________

Date	Medication	Dose	Quantity	Frequency

Authorization for Release of Medical Information

Patient Name: **Patient #:**

Social Security #
(last 4 digits): **Date of Birth:**

Please forward copies of requested records

Name:
Address:
City, State, & Zip:

Release the following:
_____Entire Health Record
_____Immunization Records Only
_____Specific Dates of Treatment: From____________to____________

_____Other ____

I am requesting that this protected information be released for the following reason: ("at the request of the individual" is all that is required if you do not desire to state a specific purpose.)

☐ This request is being made because I am transferring care to another primary care provider or leaving the area.

☐ This authorization shall remain in effect until ________________ (up to 6 months) at which time this authorization expires.

☐ I also authorize for the release of information regarding assessment, diagnosis, and treatment of alcohol and / or substance abuse.

☐ I also authorize for the release of information regarding diagnosis and or treatment of AIDS or HIV.

I understand that I have the right to revoke this authorization, in writing, at any time by sending a written notification to Nephrology Associates of Northern Virginia, attention Medical Release Correspondent, at the above address.

I hereby authorize Nephrology Associates of Northern Virginia to disclose my medical information as requested. Information used or disclosed by this authorization may be subject to subsequent disclosure by the recipient and no longer be protected by this rule.

THERE MAY BE A SERVICE CHARGE FOR THE COPYING OF RECORDS

Patient Name: **Phone:**

Patient Signature: ______________________ **Date:**

Legal Representative:______________________ **Date:**

Relationship:

Witnessed by:______________________ **Date:**