Columbus Nephrology, Inc.

PATIENT REGISTRATION FORM
PLEASE COMPLETE FRONT AND BACK

MRN (Office Use) Date:

Patient Information

Last Name | First Name | Middle Initial | Nickname/AKA

Mailing Address | Apt# | City | State | Zip Code

Date of Birth | Social Security Number | Gender ❑ Male ❑ Female ❑ Other

Preferred Phone #:______________________ ❑ Cell ❑ Home ❑ Work

Alternate Phone #:______________________ ❑ Cell ❑ Home ❑ Work

Email: ______________________

Ethnicity: ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ Declined to specify

Race: ❑ Asian ❑ American Indian/Alaska Native ❑ Black/African American ❑ Caucasian/White ❑ Native Hawaiian/Pacific Islander ❑ Other

Marital Status: ❑ Married ❑ Single ❑ Divorced ❑ Widowed

Do you have durable power of attorney? ❑ Yes ❑ No If yes, please provide a copy to the Front Desk

Physician and Referral Information

Primary Care Physician: ______________________ Phone:______________________

Referring Physician:______________________ Phone:______________________

Emergency Contact and Confidential Communication

Emergency Contact

1 Name:______________________ Phone:______________________

Relationship to Patient: ______________________

May we speak to this person concerning your medical concerns? ❑ Yes ❑ No

2 Name:______________________ Phone:______________________

Relationship to Patient: ______________________

May we speak to this person concerning your medical concerns? ❑ Yes ❑ No

Telecommunications

Please leave detailed messages or contact me regarding my protected health information as follows (Check all that apply)

❑ Home Phone ❑ Cell Phone ❑ Work Phone ❑ Patient Portal ❑ None

May we leave a message to return our call on your answering machine/voice mail? ❑ Yes ❑ No

Preferred Method of Contact for appointment reminders:

❑ Home Phone ❑ Cell Phone ❑ Text

Insurance & Financial Information

INSURANCE

Primary Insurance: ____________________

Policy Holder: ____________________

Relationship to Patient: ____________________

DOB: ____________________

SSN: ____________________

Employer: ____________________

Secondary Insurance: ____________________

Policy Holder (Secondary): ____________________

Relationship to Patient: ____________________

DOB: ____________________

SSN: ____________________

Employer: ____________________

FINANCIAL POLICY

By signing below, I indicate that I understand that all patients must complete the Columbus Nephrology, Inc. Patient Registration & Medical History forms before seeing the doctor. It is my responsibility to take an active role in my care and treatment by updating Columbus Nephrology, Inc. of any changes that have occurred since my last visit. If I have insurance, I need to bring my insurance card(s) with me to every visit and update Columbus Nephrology, Inc. if there are demographic changes. Columbus Nephrology, Inc. will send my claim to my insurance company. I authorize the release of all necessary information to file claims with my insurance company. A statement will be sent to me for any balance covered and not paid by insurance. Co-pays and deductibles are due at the time of service unless specified financial arrangements are made in advance. If I do not have insurance coverage, payment in full is expected at the time of service. Ultimately, I am responsible for payment of my bill.

By signing below, I am acknowledging that I have read and understand the above policy statement.

Signed: ____________________ Date: ____________________