Patient Profile 2014

PATIENT INFORMATION

Patient Medical Record #: _____ *(For office use only)*

Name: _____ Date of Birth: _____ SS# :_____

Mailing Address: _____ City: _____ State: ____ Zip Code: _____

Physical Address: _____ City: _____ State: ____ Zip Code: _____

Home Phone #: _____ Other Phone #: _____

Gender: ( ) Male ( ) Female **Race**: ( ) Caucasian ( ) African American ( ) Asian ( ) Hispanic ( ) Other

Preferred Language: _____ **Email Address**: _____

Preferred Method of Contact: ( ) Phone ( ) Email ( ) Letter

Martial Status: ( ) Single ( ) Married ( ) Divorced ( ) Widowed Spouse's Name (if applicable):_____

Patient Employment: ( ) Employed ( ) Unemployed ( ) Retired ( ) Other

Place of Employment: _____ Phone #: _____

Primary Care Physician: _____ PCP Phone #: _____

Other Physician:_____ Other Physician Phone #: _____

Home Health: _____ Home Health Phone #: _____

Pharmacy: _____ Pharmacy Phone #: _____

Nursing Home: _____ Nursing Home Phone #: _____

EMERGENCY CONTACTS

Name: _____ Phone #: _____ Relationship: _____

Name: _____ Phone #: _____ Relationship: _____

INSURANCE INFORMATION

Primary Insurance Co. Name: _____ Phone #: _____

Subscriber Name: _____ Relationship to patient: _____

Subscriber's SS#: _____ Subscriber's Date of Birth: _____

Policy #: _____ Group #: _____ Subscriber's Employer (if group ins.): _____

Secondary Insurance Co. Name: _____ Phone #: _____

Subscriber Name: _____ Relationship to patient: _____

Subscriber's SS#: _____ Subscriber's Date of Birth: _____

Policy #: _____ Group #: _____ Subscriber's Employer (if group ins.): _____

I hereby request that payment of authorized medical benefits be made on my behalf directly to Northeast Louisiana Kidney Specialists (where applicable) for services furnished to me by Michael Archie, MD, Michael Hand, MD, Richard O'Donovan, MD, Frederick B. Lee, MD, Nkeekam Anumele, MD, or Kimberly Sherrill, BC, FNP respectively. Also, I hereby authorize Northeast Louisiana Kidney Specialists to release any billing or medical information necessary to determine these benefits (or the benefits payable for related services) to my insurance carrier(s) and/or my primary care physician (where necessary). ***Further, I understand that I am financially responsible to Northeast Louisiana Kidney Specialists for any deductible, co-payments, co-insurances or any charges not covered by my insurance carrier(s).*** I understand that my personal information maintained by Northeast Louisiana Kidney Specialists is considered completely confidential and will only be disclosed to outside sources as allowed by law.

SIGNATURE: _____ **DATE:** _____

(Signature of patient or authorized representative)