

**Indiana Nephrology & Lung Care Group
Patient Registration**

Please Print

PATIENT INFORMATION

Date _____

Name:	Sex:	Birthdate:	Age:
Address:	Marital Status: ___ Married ___ Single ___ Separated ___ Widowed ___ Divorced		
City:	State:	Zip:	
Social Security No:	Occupation:		
Home Phone: ()	Employer:		
Work Phone: ()	Address:		
	City:	State:	Zip:

PERSON RESPONSIBLE FOR PAYMENT (If different from patient)

Name:	Relationship to Patient:
Address	Social Security No.:
City:	Employer:
Home Phone: ()	Address:
Work Phone: ()	City:
	State:
	Zip:

NEAREST RELATIVE NOT LIVING WITH PATIENT

Name:	Relationship to Patient:
Address:	Home Phone: ()
City:	Work Phone: ()
State:	
Zip:	

REFERRING INFORMATION

Referring Dr.:	Tel:	Family Dr.:	Tel:
Street Address:		Street Address:	
City:	State:	City:	State:
	Zip:		Zip:

PRIMARY INSURANCE COMPANY:

SECONDARY INSURANCE COMPANY:

Name:	Name:
Claims Address:	Claims Address:
City:	City:
State:	State:
Zip:	Zip:
Insured (name on card):	Insured (name on card):
Sex:	Sex:
Birthdate:	Birthdate:
Policy Holder ID or Soc Sec No.:	Policy Holder ID or Soc Sec No.:
Group or Policy No:	Group or Policy No:
Patient's Relation: ___ Self ___ Spouse ___ Child ___ Other	Patient's Relation: ___ Self ___ Spouse ___ Child ___ Other

AUTHORIZATION & ASSIGNMENT

I authorize any holder of medical information about me to release to the Health Care Financing Administration (Medicare) or any other insurance company and its agents, any information needed to determine these benefits or benefits for related services. I further request that payment of authorized Medicare, Medigap, or any other insurance company benefits be made on my half directly to Indiana Nephrology & Internal Medicine, P.C., for any services furnished to me by my physician. I acknowledge responsibility for payment of any deductibles, co-insurance, and non-covered services. This authorization is considered valid until revoked by me or my legal representative. A photocopy of this authorization shall be considered as valid as the original. If for any reason the account should become delinquent, I agree to pay for all collection and legal fees.

Patient or Legal Representative Signature

Date