Commonwealth Nephrology Associates

31 Pine Street, Suite 204 – Norfolk, MA 02056 (P) 617-739-2100 (F) 617-296-4330

Please print legibly or type

Patient Name ____ ________ DOB _______________

Sex_________ Marital Status _____________ Ethnicity ____________ Race_________ Language______________

Home Address____City, State, Zip________________

Billing Address____City, State, Zip_______________

Home Phone #______________________Cell Phone #____________________Email______________________

Referring Physician Name and Phone #____

Primary Care Physician Name and Phone #____

Emergency contact Information

Contact name____ Relationship____________________

Home Phone#____________________ Cell Phone #______________________Work Phone_______________

Primary Insurance

Insurance Name _____________________Address__________________ City, State, Zip_______________

Phone #_________________Policy #________________Group# __________________Copay________

Information of Subscriber of this Insurance

Name____ DOB ______________ Sex_________

Billing Address___________________________ City, State, Zip __________________Phone________________

Secondary Insurance

Insurance Name _____________________Address__________________ City, State, Zip_______________

Phone #_________________Policy #________________Group# __________________Copay________

Information of Subscriber of this Insurance

Name____ DOB ______________ Sex_________

Billing Address___________________________ City, State, Zip __________________Phone_______________

Tertiary Insurance

Insurance Name _____________________Address__________________ City, State, Zip_______________

Phone #_________________Policy #________________Group# __________________Copay________

Information of Subscriber of this Insurance

Name____ DOB ______________ Sex_________

Billing Address___________________________ City, State, Zip __________________Phone_______________

AUTHORIZATION

I hereby authorize my insurance benefits be paid directly to Commonwealth Nephrology Associates and acknowledge that I am financially responsible for any: deductible, unpaid balance, or non-covered services. * I acknowledge that I am responsible for acquiring a referral, if needed per my insurance guidelines. If I do not acquire a referral prior to my visit, I will be requested to sign a waiver and or reschedule my appointment. I authorize Commonwealth Nephrology Associates to release any medical information requested by my insurance company (ies). I also authorize Commonwealth Nephrology Associates to contact my pharmacy directly to obtain medication history.

X____

☐Signature of Patient or ☐Authorized-Representative ☐Parent ☐Legal Guardian

PLEASE CHECK ALL APPROPRIATE BOXES BEFORE TURNING IN FORM

HIPAA PRIVACY NOTICE

I acknowledge that I have been offered a copy of Commonwealth Nephrology Privacy Practices.

I hereby authorize:

☐ Commonwealth Nephrology to leave a detailed message (s) on the following phones that I have given them

☐ Commonwealth Nephrology to request any and all of my medical records on my behalf until revoked in writing by me

☐ Commonwealth Nephrology to communicate my medical/billing information with (list name & relationship below)

Name____Tel#______________________

Print Name of person (above line) who we can communicate medical and billing information

X____**Date:**____________________

☐ Signature of Patient or ☐ Authorized-Representative ☐ Parent ☐ Legal Guardian