# NEW PATIENT INFORMATION

## PERSONAL INFORMATION

| PATIENT'S FULL NAME | | HOME PHONE # | | CELL PHONE # | |
|---|---|---|---|---|---|
| SSN | DATE OF BIRTH | AGE | MARITAL STATUS (Circle One) S M W D SEP | | MALE ❑ FEMALE ❑ |
| STREET ADDRESS, CITY, STATE, ZIP CODE | | EMAIL ADDRESS | | | |
| MAILING ADDRESS, CITY, STATE, ZIP CODE | | PHARMACY INFORMATION & PHONE NUMBER | | | |
| EMPLOYER | | OCCUPATION | | WORK PHONE # | |
| SPOUSE OR PARENT'S NAME | | (SPOUSE OR PARENT'S) DATE OF BIRTH | | (SPOUSE OR PARENT'S) SSN | |
| SPOUSE OR PARENT'S EMPLOYER | | (SPOUSE OR PARENT'S) OCCUPATION | | (SPOUSE OR PARENT'S) WORK PHONE # | |
| NAME OF FRIEND OR RELATIVE - NOT LIVIING WITH YOU | | RELATION | | PHONE # | |
| HAS ANY MEMBER OF YOUR FAMILY BEEN TREATED BY OUR PHYSICIAN(S) BEFORE? YES NO<br>IF SO, INCLUDE FAMILY MEMBER AND NAME OF PHYSICIAN | | | | | |
| REFERRED BY | ADDRESS | | | PHONE # | |

## INSURANCE INFORMATION

| NAME OF PRIMARY INSURANCE COMPANY | | POLICYHOLDER NAME AS APPEARS ON CARD | |
|---|---|---|---|
| EFF. DATE | GROUP # | INSURED D.O.B. | POLICY, CONTRACT, OR I.D. # |
| SECONDARY INSURANCE COMPANY | | POLICYHOLDER NAME | |
| EFF. DATE | GROUP # | INSURED D.O.B. | POLICY, CONTRACT, OR I.D. # |
| OTHER INSURANCE COMPANY | | POLICYHOLDER NAME | |
| EFF. DATE | GROUP # | INSURED D.O.B. | POLICY, CONTRACT, OR I.D. # |

**ATTENTION MEDICARE PATIENTS:** EXTENDED PATIENT SIGNATURE AUTHORIZATION PROVIDER:
N. Rao Boorgu, M.D., P.C. 422 East Dr. Hicks Blvd. Florence, AL 35630 Group NPI: 1780641951 Tax I.D.: 63-0794660

**STATEMENT FOR PAYMENT OF MEDICARE BENEFITS:** I request that payment of authorized Medicare benefits be made either to me or on my behalf to **N. RAO BOORGU, M.D., P.C. / Shoals Kidney & Hypertension Center** for any services or items furnished to me by the physician(s) or supplier. I authorize any holder of medical information about me to release to health care financing administration and its agents any information needed to determine these benefits or the benefits payable for related services.

**STATEMENT FOR PAYMENT OF MEDIGAP BENEFITS:** I request that payment of authorized Medigap benefits be made either to me or on my behalf to **N. RAO BOORGU, M.D., P.C. / Shoals Kidney & Hypertension Center** for any services or items furnished to me by the physician(s) or supplier. I authorize any holder of medical information about me to release to (name of Medigap insurer) _____ any information needed to determine these benefits or the benefits payable for related services.

| BENEFICIARY'S NAME | MEDICARE # | MEDIGAP # |
|---|---|---|
| SIGNATURE OF BENEFICIARY OR PERSON SIGNING FOR BENEFICIARY<br>X | | MEDIGAP # |

**PLEASE READ:** All charges are due at the time of services; if a patient has an Insurance that requires pre-certification for hospital admissions or physician referral it is the patient's responsibility to notify our office ahead of time (48 hrs.) to assist in getting the approval of pre-cert. However, the patient is responsible for all fees, regardless of insurance coverage. It is also customary to pay for services when rendered unless other arrangements have been made in advance with our office staff. If copay for primary insurance is not paid on same day as services are rendered, there will be a $15.00 handling fee charge added to your account. If your account is turned over to a collection agency for payment, patient will be responsible for paying any collection fees.

Signature X_____ Date_____