ADVANCED KIDNEY CARE OF CENTRAL FLORIDA

3175 Citrus Tower Blvd Clermont, FL 34711 PH: (352) 240-3812 | FAX: (888) 716-2003
131 Webb Dr, Suite C Davenport, FL 33837 PH: (863) 226-4676 | FAX: (888) 716-2003

PATIENT REGISTRATION

PATIENT INFORMATION

Patient Name	**Sex: M F**	**DOB _____/_____/_____ Age:**	**Social Security #**	**Marital Status** []Single []Married[]Divorced[]Widowed
Address **City**		**State Zip**	**Phone (Home)**	**Phone (Cell)**
Email:		**How Did You Hear About Us? Family/Friend Internet Advertisement Other**		
Employer	**Employer Address**	**Occupation**	**Phone (Work)**	
Spouse's Name	**Spouse's Phone #**	**Spouse's Employer**		
Referring Provider				

PERSON RESPONSIBLE FOR PAYMENT

Name	**Relationship**	**Social Security #**	**Driver's License #**
Address **City**	**State Zip**		
Employer	**Employer Address**	**Phone (Work)**	
Credit Card Visa MC Discover Amex	**Name on Card**	**Exp**	

PRIMARY INSURANCE (Please Have Insurance Card(s) & Photo ID for Copying)

Ins Company Name & Address			
Policy Holder Name	**Relationship**	**DOB**	**Social Security #**
ID #	**Group #**		

SECONDARY INSURANCE (Please Have Insurance Card(s) & Photo ID for Copying)

Ins Company Name & Address			
Policy Holder Name	**Relationship**	**DOB**	**Social Security #**
ID #	**Group #**		

EMERGENCY CONTACT

Name	**Relationship**	**Phone (Home)**	**Phone (Cell)**	**Phone (Work)**

ADVANCED DIRECTIVE

1. Do you have a living will? Yes ___ No ___
A copy may be needed for your chart. A copy was received by this office (Date _____)

2. Have you given anyone Power of Attorney? Yes ___ No ___
A copy may be needed for your chart. A copy was received by this office (Date _____)
Name _____ Relationship _____ Date _____

RELEASE OF MEDICAL INFORMATION AND ASSIGNMENT OF BENEFITS

I hereby assign my insurance benefits to be made directly to Advanced Kidney Care of Central FL, PA and its associates, for services rendered. I hereby attest that the above insurance information is accurate and that I am an eligible member of the stated plan. I understand that I am responsible for knowing my benefits/coverage. I will be financially responsible for all charges NOT covered by my insurance company. I also agree to paying all co-payments, co-insurances and/or elective service fees at the time of service. If there are problems collecting payments, attorney's fees, collection agency costs and any related fees will be added to my bill.

I authorize the release of all information to other physicians and insurance carriers upon request for the purpose of payment for medical services and further treatment of care by another physician.

I grant permission to Advanced Kidney Care of Central Fl, PA physicians to perform such examinations and medical/therapeutic procedures as may be deemed professionally necessary for my/the patient's diagnosis and treatment.

I acknowledge receipt of the Notice of Privacy Practices.

Signature: _____ Date: _____