WELCOME TO RENAL MEDICINE INC.

PATIENT INFORMATION

Name:_____
Last First Initial

Address:_____

Home Phone: ( )_____-_____ Work Phone: ( )_____-_____ Social Security #___-____-____

Sex: ☐ Male ☐ Female Age:____ Birthdate:___/___/____ ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Employed by:_____ Occupation: _____

Employer Address: _____
Street City State Zip Code

Incase of Emergency who should be notified:_____
Phone: ( )____-_____

May we leave a message at home? ☐ Yes ☐ No At Work? ☐ Yes ☐ No

SPOUSE INFORMATION

Name:_____
Last First Initial

Address:_____
(If other than above) Street City State Zip Code

Birthdate: :___/___/____ Social Security #____-_____-_____Occupation: _____

Employed by:_____ Work Phone: ( ) _____-_____

Employer Address: _____
Street City State Zip Code

RESPONSIBLE PARTY FOR THIS ACCOUNT

Name:_____
Last First Initial

Address:_____
(If other than above) Street City State Zip Code

Home Phone: ( )_____-_____ Work Phone: ( )_____-_____

PRIMARY INSURANCE

Name of Insured:_____
Last First Initial

Name of Insurance: _____

Contract Number: _____ Group Number:_____ Insured ID Number: _____

SECONDARY INSURANCE

Name of Insured:_____
Last First Initial

Relationship to Patient: _____ Name of Insurance:_____

Contract Number: _____ Group Number:_____ Insured ID Number: _____

AUTHORIZATION AND RELEASE

I authorize Satnam S. Sandhu, M.D. / Rafael Garcia M.D. to submit any and all health care information to my insurance for their review and payment in the event the physician is submitting my insurance claim. Payment should be made to the physician. I further understand and agree to pay for services or amounts due to the physician when the physician accepts assignment. These charges could include amounts applied to my annual deductible, co-insurance, and charges denied as not covered by my insurance or considered medically unnecessary.

Signature:_____ **Date: _____**

Patient Parent Guardian

AUTHORIZATION AND RELEASE

I request that payment of authorized Medicare benefits be made on my behalf to Satnam S. Sandhu, M.D. / Rafael Garcia M.D. for any service furnished by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and it's agents any information needed to determine these benefits or the benefits payable for related medical information necessary to pay the claim. If "other health insurance" is indicated on the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance, and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

Signature:_____ **Date: _____**

Medicare Beneficiary