West Michigan Nephrology
1250 Mercy Drive Suite 101
Muskegon, MI (231) 733-1912

NEW PATIENT INFORMATION

Date: _____

Please fill out completely

_____ _____ Sex: M / F _____
Patients Name (please print) Birth Date Social Security Number

_____
Street Address City State and Zip Code Home Phone

_____
Patient's or Parents Employer Occupation (indicate if student) Business phone with Ext

_____
Primary physician Pharmacy used

_____
Spouse or Parent's Name Social Security Number Birth Date

_____
Spouse or Parent's Employer Occupation Business Phone with Ext

_____
Employers Street Address City and State Zip Code

PLEASE READ: **ALL COPAYS ARE DUE AT THE TIME OF SERVICE**.

Primary insurance	Secondary insurance
Insurance _____	insurance _____
ID #_____Group#_____	ID #_____Group#_____
Main policy holder_____DOB__-__-____	Main policy holder_____DOB__-__-____
Insurance address _____	Insurance address _____

Please bring your insurance cards with you to every appointment.

ALL PROFESSIONAL SERVICES ARE CHARGED TO THE PATIENT. THE PATIENT IS RESPONSIBLE FOR ALL FEES, REGARDLESS OF INSURANCE COVERAGE. IT IS CUSTOMARY TO PAY FOR SERVICES WHEN RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE WITH OUR ACCOUNTS MANAGER.

INSURANCE AUTHORIZATION AND ASSIGNMENT OF BENEFITS

I request that payment of Medicare / Other Insurance company benefits be made either to me or on my behalf to **West Michigan Nephrology; PLC** for any services furnished me by that party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

I authorize any holder of medical or other information about me to release to the Social Security Administration and CMS or its intermediaries or carriers, any information needed for this or a related Medicare claim/Other Insurance Company Claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. I understand it is mandatory to notify the health care provider or any other party who may be responsible for paying for my treatment. (Section 1128B of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding this information) This assignment will remain in effect until revoked by me in writing.

_____ _____
Signature of Patient or Responsible Party **Date**