Nephrology & Hypertension Associates, P.C.

Gegory Buller, MD, F.A.C.P. **David Roer, MD, F.A.C.P.**
Sina Raissi, MD **Marilyn Olsen, PA-C**

PATIENT INFORMATION

NAME:____ DATE OF BIRTH:________________

SOCIAL SECURITY #________________________ MALE ⬭ FEMALE ⬭

ADDRESS:__________________________________ APT#________CITY:__________________________

STATE:_______ ZIPCODE___________________

HOME TELEPHONE___________________________ CELL TELEPHONE:__________________

EMPLOYER:________________________________ WORK TELEPHONE:__________________

IF UNEMPLOYED, PLEASE CHECK THE APPROPRIATE BOX

RETIRED ☐ DISABLED ☐ STUDENT ☐ OTHER ☐ ____________

PRIMARY CARE PHYSICIAN:________________________________

PHYSICIAN TELEPHONE:____________________________________

REFERRING PHYSICIAN (ONLY IF DIFFERENT FROM PRIMARY CARE)
PHYSICIAN:____

1. EMERGENCY CONTACT NAME AND RELATIONSHIP:__________________________________
   TELEPHONE:__________________________
2. EMERGENCY CONTACT NAME AND RELATIONSHIP:__________________________________
   TELEPHONE:__________________________

PLEASE PRESENT INSURANCE CARDS AT THE TIME OF VISIT TO AVOID ANY UNNESECCARY CHARGES TO YOUR ACCOUNT. CO-PAYS ARE EXPECTED UPON ARRIVAL OF YOUR VISIT

I AUTHORIZE RELEASE OF ANY INFORMATION CONCERNING MY HEALTH CARE, ADVICE, AND/OR TREATMENT PROVIDED FOR THE PURPOSE OF EVALUATING AND ADMINISTERING CLAIMS FOR INSURANCE BENEFITS. I ALSO HEREBY AUTHORIZE PAYMENT OF INSURANCE BENEFITS OTHERWISE PAYABLE TO ME DIRECTLY TO THE DOCTOR. IN THE EVENT OF NON-PAYMENT THROUGH INSURANCE OR OTHERWISE, I EXCEPT FULL RESPONSIBILITY FOR ANY BALANCES OWED. NEPHROLOGY AND HYPERTENSION ASSOCIATES MAY ALSO PROVIDE INFORMATION THEY OR THEIR AGENTS MAY DEEM APPROPRIATE TO MY PHYSICIANS OR ATTORNEY CONCERNING MY ILLNESS, TREATMENT AND OR PROGNOSIS.

SIGNATURE OF PATIENT OR LEGAL GUARDIAN

SIGNATURE:____________________________________ DATE:__________________________

SEE REVERSE SIDE

INSURANCE INFORMATION

INFORMATION PROVIDED WILL BE USED TO COLLECT PAYMENT FOR SERVICES
THANK YOU

PRIMARY INSURANCE:

PATIENT NAME_______________________________ DATE OF BIRTH______________________

NAME OF INSURED (ONLY IF DIFFERENT THAN PATIENT)_____________________________
RELATIONSHIP TO PATIENT______________________ DATE OF BIRTH__________________

INSURANCE COMPANY___________________________ ID NUMBER_______________________
GROUP NUMBER__________________SOCIAL SECURITY NUMBER______________________

EMPLOYER NAME (IF INSURANCE IS THROUGH WORK)______________________________

CO-PAY AMOUNT:__________________________

SECONDARY INSURANCE:

NAME OF INSURED______________________RELATIONSHIP TO PATIENT________________
DATE OF BIRTH____________________

INSURANCE COMPANY_________________________________ ID NUMBER__________________
GROUP NUMBER _______________________ SOCIAL SECURITY NUMBER________________

SIGNATURE OF PATIENT OR LEGAL GUARDIAN

SIGNATURE:______________________________________ DATE:__________________________

INSURANCE COVERAGE WILL BE REVIEWED AT THE DISCREPENCY OF THE OFFICE TO ENSURE CORRECT BILLING INFORMATION FOR SERVICES RENDERED.

CO-PAYMENT IS EXPECTED AT THE TIME OF YOUR VISIT