Acct #______________________

Balboa Nephrology Medical Group, Inc.

Date_____________________ Doctor____

☐ New Patient ☐ Update Office____

PATIENT INFORMATION

Name (Last, Frist, Middle) *please print clearly*		Sex		Date of Birth
		☐ M	☐ F	/ /
Current Address		Single ☐ Married ☐ Divorced ☐	Widowed ☐	Other ☐
City	State	Zip Code		Home Telephone No. ( )
Social Security No.	Driver's License No.	Work Telephone No. ( )		Cell Phone No. ( )
Mailing Address (if different than above)		City	State	Zip Code
Employer's Name and Address		City	State	Zip Code
Referred by:		Telephone No.		
List any allergies to medications:				

PERSON TO NOTIFY IN AN EMERGENCY

Name (Last, First, Middle)	Relationship	Home phone ( )	Work Phone ( )	Cell Phone ( )
Address		City	State	Zip Code

INSURANCE INFORMATION

PRIMARY INSURANCE		Membership No.		Group No.
Billing Address		City	State	Zip Code
Telephone No. ( )	Contact Person	Insurance Med. Group	Effective Date	Copay
Insured's name (Last, First, Middle)		Relationship	Date of Birth / /	Social Security No.
Primary Care Physician			Telephone No.	
SECONDARY INSURANCE		Membership No.		Group No.
Billing Address		City	State	Zip Code
Telephone No. ( )	Contact Person	Insurance Med. Group	Effective Date	Copay
Insured's name (Last, Frist, Middle)		Relationship	Date of Birth / /	Social Security No.

Do you wish to have your insurance(s) billed for you? ☐ YES ☐ NO

AUTHORIZATION TO TREAT AND RELEASE OF INFORMATION ☐ HCFA

I hearby agree to accept treatment by Balboa Nephrology Medical Group, Inc. and authorize Balboa Nephrology Medical Group, Inc. to release my medical information per request of my insurance company.

Date______________________________ Signature____

ASSIGNMENT OF BENEFITS

I hearby authorize direct payment from my insurance carrier to Dr.______________________________________or Balboa Nephrology Medical Group, Inc. for medical services provided to me. I understand that I am financially responsible for payment of medical services provided by Balboa Nephrology Medical Group, Inc.

A $10.00 fee will be charged for returned checks

Date______________________________ Signature____