PATIENT REGISTRATION

NEPHROLOGY & HYPERTENSION

2402 Camden Street, Suite 700 • Wilson, NC 27893
Phone: 252.293.9898 • Fax: 252.293.9915

4082 Capital Drive • Rocky Mount, NC 27804
Phone: 252.293.9898 • Fax: 252.293.9915

Patient Information

Full Name ______________________ Nickname ______________
(Name as it appears on your insurance documents)

Social Security # ______________ Date of Birth ______________

Gender ❑ Male ❑ Female Marital Status ______________

Address ______________________

City ______________ State ______ Zip Code ______________

Home Phone # ______________ Cell # ______________

Email ______________

Prefered contact ❑ Email ❑ Home Phone ❑ Cell Phone May we leave a voicemail ❑ Yes ❑ No

Employer ______________ Work # ______________

May we call you at work ❑ Yes ❑ No Ext. # ______________

Pharmacy(ies) ______________ Phone # ______________

______________ Fax # ______________

Emergency Information

Contact Person ______________ Phone # ______________

You may disclose information regarding my health condition(s) and/or medical records to the following people:

Name ______________ Relationship ______________

Name ______________ Relationship ______________

Will Bynum, M.D., P.A. will not release any information to an individual not listed above without prior authorization.
I understand that I am responsible for contacting Will Bynum, M.D., P.A. for changes I wish made in my list above.

Insurance Information

Primary Insurance Co ______________ Policy # ______________

Policy Holder ______________ Subscriber # ______________

Secondary Insurance Co ______________ Policy # ______________

Policy Holder ______________ Subscriber # ______________

Third Insurance Co ______________ Policy # ______________

Policy Holder ______________ Subscriber # ______________

I accept the financial responsibility for my medical services.

Patient Signature ______________________ Date ______________

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Consent for Use and Disclosure of Health Information

SIGNATURE FOR CONSENT FOR PRACTICE TO USE AND DISCLOSE

I, ______________________________, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent for you to use and disclose my protected health information to carry out treatment, payment activities, and health operations.

Signature ______________________________ Date ______________________________

SIGNATURE OF PERSONAL REPRESENTATIVE ON BEHALF OF PATIENT

If you are a Personal Representative for the patient and you are signing this Consent form on behalf of the patient, please complete the following:

Personal Representative's Name ______________________________

Relationship to Patient ______________________________

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

Include Completed Consent Form in the patient's record.