Haddon Renal Medical Specialists, PA

Today's Date_____/_____/_____ Date of Birth_____/_____/_____
Last Name_____ First Name_____ Middle initial____
Address _____Home #_____Cell#_____
City _____State_____ Zip_____
Are you: ____Single ____Married _____Divorced _____ Widowed

Employer Information

Employer Name: _____Phone #:_____
Address: _____ City: _____ State: ___ Zip Code: _____
Occupation: _____Work Phone #:_____
Employee Status: □ Full-time □ Part-time □Self Employed
□Retired □ Unemployed □Workmen's Comp □ Disability

Primary Insurance

Insurance Company _____Address_____
I.D #_____Group#_____
If different from patient: please complete below
Person responsible for insurance _____Relationship to patient_____
Birth Date: ____/____/_____ SS#_____ Home #_____
Address_____City_____State_____Zip_____
Responsible Party Employed by_____
Effective Date:_____

Secondary or Additional Insurance

Insurance Company_____ Address_____
ID#_____ Group#_____
If different from patient: please complete below
Person responsible for insurance _____Relationship to patient_____
Birth Date: ____/____/_____ SS#_____ Home #_____
Address_____City_____State_____Zip_____
Responsible Party Employed by_____
Effective Date:_____

Assignment and Release

I hereby authorize payment directly to "Haddon Renal Medical Specialists" of all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance and for all services rendered on my behalf or my dependents.

I authorize the provider or supplier of services in this office to release the information required to secure the payments of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party _____Date_____