PRINCE GEORGE'S KIDNEY CARE (Babak Razi, MD)

Patient's Information

Name:_____ Date:_____

Address:_____ SSN:_____

City:_____ State:_____ Zip:_____ Height:____'____'' Weight:_____

Reason for Visit:_____ **M**_____ **F**_____

Contact Phone: (_____)_____ Cell Phone: (_____)_____ Work: (_____)_____

Date of Birth:_____ Ref by:_____ Race:_____

E-mail address:_____

Occupation: _____ Employer: _____

If under 18: Parent/Guardian_____

Emergency Contact Information:

Name:_____ Address:_____

Relationship:_____ Phone: (_____)_____

Billing Information

Responsible Person other than patient:_____ Relationship:_____

Billing Address:_____ Phone: (_____)_____

INSURANCE INFORMATION

Primary
Insurance Company:_____
Name of Insured if other than Patient:_____ Relation:_____
Identification Number:_____ Group Number:_____
Secondary
Insurance Company:_____
Name of Insured if other than Patient:_____ Relation:_____
Identification Number:_____ Group Number:_____

Assignment of Insurance Benefits - Medicare - Medicaid

I hereby authorize direct payment of medical/surgical benefits to Babak Razi, MD, for services rendered by him in person or under his supervision. I understand that I am financially responsible for any balance not covered by my insurance carrier.

Authorization to release information

I hereby authorize Babak Razi, MD to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefit.

A photocopy of these assignments shall be valid as the original.

Patient Name:_____ Date:_____

Parent / Guardian:_____ Signature:_____