Idaho Nephrology Associates
5610 West Gage St. Suite A
Boise, Idaho 83706
(208) 367-3370

PATIENT DEMOGRAPHIC FORM

Patient Name:_____

Address:_____

Telephone Number:_____ Birthdate:_____

Sex:_____ Social Security Number:_____

Marital Status: Married_____ Single_____Divorced_____Widowed_____

Employer Name:_____

EmployerAddress:_____

Employer Phone Number:_____

Nearest Relative or Person we may contact in case of an emergency (outside of your own home):

Name:_____ Relationship:_____

Address:_____ Telephone Number:_____

ASSIGNMENT OF BENEFITS AUTHORIZATION FOR TREATMENT:

I hereby authorize treatment and authorize the provider of medical services to release information for these services to my insurance carrier for payment. I further authorize that benefits be made payable to the provider on my behalf or to myself. I understand that I am financially responsible for the charges not covered by my insurance carrier.

Patient or Authorized Representative:_____

_____

Primary Care Physician Address Phone

Date:_____