BERGEN KIDNEY CENTER

Patient Information Sheet

Samuel A. Agahiu, MD
Louis C. Jan, MD
Marc S. Zelkowitz, MD

Date: _____

Patient Name: _____ Date of Birth: _____
First, Middle Initial, Last
Email Address: _____@ _____.com (if applicable)

Home Address: _____ State: _____ Zip:_____

Home Phone: ( ) _____-_____ Cell: ( )_____-_____ Business: ( )_____- _____

Gender at birth: __Male __Female
Marital Status:__Single __Married __ Divorced __Widowed

Social Security Number: _____ Race: _____ Ethnicity: _____

Preferred Language: _____ Preferred Contact Method: ()Email ()Phone_____

Emergency Contact Name: _____ Phone: ( )_____-_____

Referring Physician: _____ Phone: ( )_____-_____

Pharmacy/Location: _____ Phone: ( )_____-_____

_____ ***HIPPA CONSENT TO LEAVE MESSAGE***

I wish to be called regarding my care and follow-up. The best number to reach me is: _____-_____-_____

I do, I do not (circle one) give permission to leave relevant medical information on my answering machine or voicemail.
I do, I do not (circle one) want relevant medical information shared with the person who may answer the telephone.
The name(s) of the individual(s) with whom you may leave pertinent information are:
_____, _____, _____

Patient or Responsible Party Signature: _____ Date: _____

Insurance/Payment/Carrier Information:

Insured Party:(If other than patient) _____ DOB: _____

Relationship to patient: _____ Social Security Number: _____

Employer: _____

Primary Insurance Plan: _____ Member ID: _____

Claims Address: _____

Phone: _____ Effective Date: _____

Secondary Insurance Plan: _____ Member ID: _____

Claims Address: _____

Phone: _____ Effective Date: _____

AUTHORIZATION FOR RELEASE OF INFORMATION AND THIRD PARTY PAYMENT

I authorize the release of any medical information necessary to process my claim, and request payment of any medical insurance benefits to be paid directly to Drs. Agahiu, Jan or Zelkowitz. I understand that I am responsible for any amount not covered by my insurance.

_____ _____ _____

Signature of Patient Responsible Party (if other than patient) Date

MEDICARE PATIENTS ONLY

I request that payment of authorized Medicare benefits be made on my behalf to Drs. Agahiu, Jan or Zelkowitz, for any services furnished to me by the physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services. I request payment of Medigap benefits be paid to Drs. Agahiu, Jan or Zelkowitz.

_____ _____ _____

Signature of Patient Responsible Party (if other than patient) Date