South Florida Nephrology Group, P.A.

722 Riverside Drive
Coral Springs, Fl. 33071
(954) 345-4333

850 Riverside Drive
Coral Springs, Fl. 33071
(954) 510-4062

8251 W. Broward Blvd. Suite 100
Plantation, Fl. 33324
(954) 908-1024

PATIENT INFORMATION

Patient Name: ______________________________________ SS # _____/____/_______

Address:____ ____ Phone: ( ) _____/______

City: ______________________________________ State: _____ Zip: _______

Date of Birth: ____/____/____ Age: ___________ Male □ Female □

Employer: __________________________________ Occupation: _____________

Business Address:___________________________________ Phone: ( ) _____/_______

Spouse's Name: ________________________________ Phone: ( ) _____ / ______

Nearest Relative: _______________________________ Relative Phone: ( ) _____ / ___

Primary language: _______________ **Email:** ________________________

Medications presently taken for all conditions: ____
____
____

Preferred Pharmacy: _________________________ Phone Number: ( ) _________________

Known allergies to Drugs / Food: ____
Past hospital / Surgeries: ____

Please check which problems you have with the following systems:

□	Eyes / Glaucoma	□	Nose / Sinuses	□	Teeth	□	Throat
□	Ears	□	Thyroid	□	Muscles	□	Nervous System
□	Repro System	□	Lungs	□	Heart	□	Circulation
□	Breasts	□	Stomach / Liver	□	Intestines	□	Kidneys
□	Prostate	□	Skin				
□	Other:						

____
Immune disorders: ____

Family history disease: Please check **Yes** or **No**

Kidneys	□ Yes □ No	Digestive System	□ Yes □ No	Diabetes	□ Yes □ No
Hypertension	□ Yes □ No	Cancer	□ Yes □ No	Heart	□ Yes □ No
Lung	□ Yes □ No	Bone	□ Yes □ No	Excessive Bleeding	□ Yes □ No

Anemia □ Yes □ No Restrictions to medications □ Yes □ No

If yes please explain:

____

Race: □ White □ Black of African American □ American Indian and Alaska native □ Asian
□ Native Hawaiian □ other race □ Two or more races.

Ethnic Group: □ Hispanic or Latino
□ Not Hispanic or Latino

Do you have any advance directives? Living Will □ Yes □ No
Health Care Proxy □ Yes □ No

Physician release - assignment - financial responsibility - consent for treatment – medical info release:

I hereby authorize payment directly to South Florida Nephrology Group PA for my insurance company and further authorize the release of any medical information required by my insurance carrier(s) or any heath care provider that provides me with medical care.
A copy of the authorization may be used in lieu of the original. I authorize any holders of medical or other information about me to release to the Social Security Administration and Health Care Financing administration of or its carriers any information needed for use on a related Medicare claim (if applicable).
I request payment of medical insurance benefits to the party who accepts assignment.
I certify that this request has been made voluntary. I understand that I may revoke this authorization at any time except to the extent that action has already been taken to comply with it.

I understand that I am financially responsible for charges not covered by my insurance.

Consent for treatment:
I consent to examination and treatment as a patient, to the performance of any medical care, treatment surgical or diagnostic procedure that the physician treating the patient deems necessary under the circumstances.

Patient or representative signature:

______________________________ ______________________________

Print Name **Signature**

Date: ____ / ____ 2016

**** If you had downloaded this form from our website, please fill it out, prior to your office visit and bring it with you, or you could fax it at: (954) 345-4334 or you could upload it thru our website: www.sfng.org*