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Carol ine Kwon, M.D.

PATIENT REGISTRATION FORM

Please Print All Requested Information

Full **Legal** Name _____ _____
Last First MI

SSN#_____ Date of Birth_____ Sex (circle) **M F**

Marital Status (circle) **S M D W**

Preferred Language _____

(PLEASE CIRCLE ONE) 1) Ethnicity: Hispanic or Non-Hispanic

2) Race: White Black Asian Indian/Alaskan

Pacific Islander Other/Mult

Address_____
Street City State ZIP

Email Address _____

Home Phone_____ **Cell** _____**Work** _____

Primary Care Dr./Referring Dr. (Required) _____Physician's Office Phone_____

Full **Legal** Name _____ _____

Last First MI

SSN# _____ Date of Birth _____

EMERGENCY CONTACT

Name _____ Relationship _____ Telephone _____

NEXT OF KIN (If different from emergency contact)

Name _____ Relationship _____ Telephone _____

MEDICAL INSURANCE INFORMATION (All fields are required to be filled out)

Primary Ins. Co._____ **Policy/ID#** _____ **Group#** _____

Secondary Ins. Co. _____ **Policy/ID#** _____ **Group#** _____

MEDICAL CONSENT & ASSIGNMENT OF BENEFITS

I hereby authorize the Virginia Nephrology Group physician to examine and prescribe me such treatment(s) as deemed necessary or advisable based on my diagnosis. I hereby authorize the Virginia Nephrology Group to release any information acquired in the course of my examination or treatment to the insurance company. I understand that the Virginia Nephrology Group will file my insurance claim as a courtesy and I authorize my insurance benefits to be paid directly to the Virginia Nephrology Group. I also understand that I am financially responsible for all medical fees relating to my care. Should my insurance company deny a claim or leave any deductible, co-pay and/or coinsurance amount to my responsibility, I understand I am responsible for these payments. This authorization shall remain valid until revoked in writing.

_____ _____

Signature Date