

**Beckie Michael DO, FACOI, FASN**  
Marlton Nephrology and Hypertension, LLC

Today's Date \_\_\_\_\_

**PATIENT DEMOGRAPHICS**

Last Name	First Name	Middle Name
Home #	Work #	Cell #
Address	City	State, Zip
Date of Birth	SS #	Marital Status      Sex

**EMPLOYMENT INFORMATION**

Employer	Occupation
Address	City, State, Zip
Emergency Contact, Name and Phone #	

**INSURANCE INFORMATION**

<b>Primary INS</b>	Effective date
ID #	Group #
<b>Subscribers Name</b>	<b>Relationship to Patient</b>
<b>SS # of Subscriber</b>	<b>Date of Birth of Subscriber</b>
Address	City, State, Zip
<b>Secondary INS</b>	Effective date
ID #	Group #
Subscribers Name	Relationship to Patient
SS # of Subscriber	Date of Birth of Subscriber
Address	City, State, Zip

**PHYSICIAN/PHARMACY INFORMATION**

Physician's Name	Phone #	Fax #	NPI #
Address	City, State, Zip		
Other Doctor	Address/Phone/Fax		
Other Doctor	Address/Phone/Fax		
Pharmacy Local	Address/Phone/Fax		
Pharmacy Mail Order	Address/Phone/Fax		

**Assignment of Benefits:** I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, including Medicare, private insurance, and any other health plan to Dr. Beckie Michael. This assignment will remain in effect until I revoke it in writing. A photocopy of this assignment is to be considered valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignment release and all information necessary to secure payment.

Signature \_\_\_\_\_ Date \_\_\_\_\_