Texas Institute for KIDNEY AND ENDOCRINE DISORDERS

PATIENT INFORMATION FORM

Primary Care Provider:	Referring Provider:	
Last Name:	First Name:	MI:
Address:	City:	State: Zip:
Home Phone:	Mobile Phone:	May we text you?
Date of Birth:	Age:	Email Address:
Social Security Number:	Driver's License Number:	State: Marital Status:
Race:	Ethnicity:	Language:
Patient Employer:	Employer Phone Number:	
Spouse Name:	Date of Birth:	Age:
Spouse Employer:	Employer Phone Number:	Mobile Number:
Emergency Contact Name:	Relationship to Patient:	Contact Number:
May we leave a confidential detailed message for you? Yes _____ No_____ Preferred Method of Contact? _____		
Pharmacy Information: Name: Address: Phone:	**Preferred Lab:** Name: Address: Phone:	**Radiology Testing Facility Preferred:** Name: Address: Phone:

Patient Responsibility

I certify that the above information is true and correct to the best of my knowledge. I authorize payment of benefits directly to Dr. Lance A. Sloan, M.D. and I authorize Lance A. Sloan to appeal all insurance claims as appropriate on my behalf. I understand that I have a contract with my insurance company and it is my responsibility to understand my benefits and how my plan works. **Verification of your benefits is not a guarantee of payment as quoted by the health plan.** My health plan determines whether a claim is eligible for payment at the time it is received and processed based on plan description, member eligibility, terms, exclusions, limitations, policy guidelines, waivers, riders, benefits maximums, pre-existing and coverage at the time of service. I understand that legally my insurance has 45 days to pay claims at which point I may be billed in full. I agree to be fully responsible for all lawful debts incurred by myself for the services whether covered by insurance or not. I authorize the undersigned Provider to release confidential and /or protected health information (PHI) or any information necessary to process this or any future or past claim while my examination, treatment, operations, or payment as defined by HIPPA. This authorization shall remain valid unless revoked in writing by patient.

Signature: **Date:**