Kidney Care Bermuda

BERMUDA INTERNAL MEDICINE

PATIENT INFORMATION

PLEASE PRINT CLEARLY

Last Name: _____ First Name: _____ Middle: _____

Gender: M / F | Date of Birth:(d) _____(m)_____(y)_____ | Marital Status: Single | Married | Divorced |Widowed

Address: _____

Parish: _____Zip Code: _____

Contact Information: Primary Number (Please Tick One) □ Home | □ Work | □ Cell

Home: _____ Work: _____ Mobile: _____

Email: _____ **Employer: _____**

Referred by: _____ **General Practitioner**: _____

Emergency Contact: Name: _____Relationship: _____

Mobile: _____ Home: _____ Work: _____

INSURANCE INFORMATION: (PLEASE CIRCLE INSURANCE COMPANY)

Argus | BF&M | CG | CASH | Future Care | GEHI / GEHI (Police, Prison) | HIP | HIP-Argus | HIP-BF&M | HIP-CG

Group/Policy# _____ Certificate # _____ Effective Date: _____

POLICY HOLDER: Relationship to patient: (Please circle) Self Spouse Parent **Employer: _____**

Last Name: _____ First Name: _____ Date of Birth _____

I, the undersigned, hereby authorize payment of insurance benefits for the service/s rendered to the patient named on this form, together with the release of any medical information necessary to process a medical claim.

Payment is required at the time services are rendered. I understand and accept that I am ultimately responsible for payment of services rendered by Kidney Care Bermuda & Bermuda Internal Medicine if such services are not paid for by my insurance.

Patients who do not have an email address on file will receive paper statements, which will incur a charge of $1 per statement.

I hereby authorize Kidney Care Bermuda, Bermuda Internal Medicine and whomever may be designated as assistants to administer such examination and treatment as they deem necessary.

I Understand that the full Patient Information, Fee Schedule and Patient Rights and Responsibilities can be found on our websites. Kidneycare.bm & Bim.bm.

Signature of Patient / Guarantor: _____ Date: _____