PASO DEL NORTE NEPHROLOGY

□MANUEL LOPEZ, M.D., P.A.

□DAVID OPAWUMI, M.D., P.A.

10201 GATEWAY WEST STE. 210 EL PASO, TX 79925

PATIENT REGISTRATION

□ NEW □ UPDATE

PATIENT INFORM	REFERRED BY:									
LAST NAME F	IRST NAME	MI	SEX	□M	EMPLOYMENT	□ FULL	TIME	STUDENT		
				□F	STATUS	□ PART	ΓΙΜΕ	STATUS		
ADDRESS		APT				□ RETIRI	ED	□ FULL TIME	•	
						□ NONE		□ PART TIM	=	
CITY	STATE			ZIP	EMPLOYER'S OF	R SCHOOL NA	ME	TELEPHO	NE	
TELEPHONE		□ SINGL	.E	□ OTHER	EMPLOYER'S	OR SCHOO	OL ADDRES	SS		
		□ MARE								
SOCIÁL SECURITY N	UMBER		F BIRTH	AGE	CITY		STATE	ZIP CO	DE	
		1	•			*				
PRIMARY INSURANC	E INFORMAT	ION	······································		SECONDARY	INSURANC	E INFORM	ΙΔΤΙΩΝ		
MEDICARE MEDICAID		CIGNA	Healthspring	НМО	MEDICARE	MEDICAID	BC/BS	AETNA	CIGNA	
	1			_				l ₀		
OTHER PLEASE SPECIFY NAME				OTHER SPECE			SPECFITY N	,,, ,., -		
ID/ POLICY NUMBER GRO		GROUP N	OUP NUMBER		ID NUMBER GROUP I		GROUP NUM	NUMBER		
TO THE PROPERTY OF THE PROPERT				•	DI FACE PRECENT MOURANCE CARR TO FROM TRECK					
PLEASE PRESENT INSURANCE CARD TO FRONT DESK WHEN THIS FORM IS COMPLETE					PLEASE PRESENT INSURANCE CARD TO FRONT DESK WHEN THIS FORM IS COMPLETE					
	EN THIS FORW IS	COMPLE			WISER THIS FORM IS COMPLETE					
PRIMARY LEAVE		LEAVE B	BLANK IF COVERED		SECONDARY					
INSURED INFORMATION BY M			CARE/ MEDIC		INSURED INFORMATION					
INSURED'S RELATIONSHI	P		SELF CHILD		INSURED'S RELATIONSHIP			SELF	□CHILD	
TO PATIENT			□SPOUSE □ OTHER					□SPOUSE	□ OTHER	
INSURED'S NAME			SEX DM		INSURED'S NAME			SEX	о М о F	
INSURED'S ADDRESS					INSURED'S ADDRESS					
CITY STATE ZIP					CITY STATE ZIP					
	OiME		2411				0.7.112			
TELEPHONE		OTATUO	□ SINGLE	□ OTHER	TELEPHONE			CTATUC	□ SINGLE	
		STATUS	□ MARRIED					STATUS	□ MARRIED	
INSURED'S EMPLOYERS NAME		TELEPHONE		INSURED'S EMPLOYERS NAME			TELEPHONE			
SOCIAL SECURITY NUMBER		DATE OF BIRTH		SOCIAL SECURITY NUMBER			DATE OF BIRTH			
IN CASE OF EMERGENCY						RESPONSIE	BLE OR THIRI	D PARTY		
NAME TELEPHONE			COMPLETE THIS SECTION ONLY IF THE PARTY TO BE							
I WILL		()		BILLED IS DIFFERENT FROM THE ABOVE INFORMATION						
NAME	TELEPHONE		NAME			TELEPHON	<u> </u>			
()										
RELEASE AND ASSIGNMENT					ADDRESS APT			APT		
AUTHORIZE RELEASE OF ANY INFORMATION NECESSARY TO					CITY		STATE	ZIP		
PROCESS MY INSURANCE CLAIMS AND ASSI										
PAYMENT DIRECTLY TO:								•	·	
PASO DEL NORTE NEPHROLOGY										
SIGN: DATE:					EMAIL					

PASO DEL NORTE NEPHROLOGY PATIENT RECORD OF DISCLOSURE

PATIENT RECORD OF DISCLOSURE								
Name	☐ Male ☐ Female	D.O.B.						
Record of Disclosures of F	Protected I	Health Information	on					
n general the HIPAA (Health Insurance Portability and to request a restriction on uses and disclosures of their proprovide the right to request confidential communications of means such as sending correspondence to the individuals	otected health r that a comm	n information (PHI). Thus information of PHI be re	The individual is also made my alternative					
The privacy rule generally requires health care providers to equest for PHI to the minimum necessary to accomplish to disclosures made pursuant to an authorization requested.	he intended p	ourpose. These provi						
wish to be contacted in the following manner (check all the	nat apply):							
Home Telephone:	Writte	n Communication:						
☐ Ok to leave message with detailed information	□ Ok 1	to mail to my home a	ddress					
☐ Leave message with call back number	☐ Ok to mail my work/office address							
	□ Ok 1	to fax to this number						
Work Telephone:								
Ok to leave message with detailed information								
Leave message with call back number only								
Acknowledgements of Receipt of Notice of Privacy Pra	actices							
have been presented with a copy of the Notice of Privacy and disclosed as permitted under federal and state law, ar PATIENT SIGNATURE								
PRINTED NAME		BIRTHDATE						
RECORD OF DISCLOSURE OF PR	ROTECTED I	HEALTH INFORMAT	TION					
List names of persons authorized to receive prote	ected healt	h information abo	ut patient:					
Name	Re	lationship	Date Initials					
1.		·						
	I							
2.								
3.								
3. 4.								
3.								
3. 4.	ocument date	and time notice was	presented and sign					

Signature _____