

NEW PATIENT INFORMATION:

LAST NAME _____ FIRST NAME/INITIAL _____

SOCIAL SECURITY # _____ DATE OF BIRTH _____

SEX _____ MARITAL STATUS _____ RACE _____

ADDRESS _____ CITY/STATE/ZIP _____

PRIMARY CARE DR _____ PHARMACY _____

HOME PHONE # _____ CELL PHONE # _____

EMERGENCY CONTACT:

NAME _____ PHONE# _____

RELATIONSHIP _____

INSURANCE INFORMATION:

PRIMARY INS COPANY _____ POLICY/GROUP # _____

PRIMARY INS POLICY HOLDER NAME/DOB _____

SECONDARY INS CO INFORMATION _____

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE PHYSICIAN OF THE SURGICAL AND/OR MEDICAL BENEFITS, IF ANY; OTHERWISE PAYABLE TO ME FOR HIS/HER SERVICES AS DIRECTED, REALIZING THAT I AM RESPONSIBLE FOR PAYMENT OF ANY NON-COVERED SERVICES. I ALSO AUTHORIZE THE PHYSICIAN TO RELEASE ANY INFORMATION ACQUIRED IN THE COURSE OF MY TREATMENT WHICH IS NECESSARY TO PROCESS INSURANCE CLAIMS.

SIGNATURE _____

DATE _____

Carolina Nephrology, P.A.

O: 919.580.1026 | F: 919.580.1027 | TF: 877.293.1973



R. David Kemp, M.D.
Ajay I. Shreenath, M.D.
Roopa Shah, M.D.

1704 A Wayne Memorial Dr.
Goldsboro, NC 27534
919.580.1026
F: 919.580.1027

331 North Blvd. Ste. 40
Clinton, NC 28328
919.580.1026
F: 919.580.1027

I HEREBY GIVE CONSENT FOR THE FOLLOWING FAMILY MEMBER(S) TO RECEIVE INFORMATION REGARDING MY MEDICAL CONDITION:

NAME _____

NAME _____

NAME _____

NAME _____

SIGNATURE _____

DATE _____

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AGREEMENT TO BRING BOTTLES OF MEDICATION TO APPOINTMENTS

Dr. Robert Kemp and Dr. Ajay Shreenath request that patients bring in ALL bottles of medications to include over-the-counter medication as well as medications prescribed by other physicians so that medication reconciliation will be accurate. A written list of medications will not be accepted. Starting November 01, 2015 if you do not have the actual bottles of medications you are taking, your appointment may be rescheduled.

Robert Kemp, M.D.

Ajay Shreenath, M.D.

Roopa Shah, M.D.

Patient's Signature

Date

Carolina Nephrology, P.A.

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ASSIGNMENT OF BENEFITS

I HEREBY CONSENT TO TREATMENT FOR MY MEDICAL PROBLEM
BY CAROLINA NEPHROLOGY, P.A.

I HEREBY AUTHORIZE PAYMENT OF BENEFITS DIRECTLY TO
CAROLINA NEPHROLOGY, P.A., FOR ANY SERVICES PROVIDED
TO ME, AND I AUTHORIZE RELEASE OF ANY PERTINENT
INFORMATION REQUIRED FOR PAYMENT, OR IN THE PURSUIT
OF CONSULTATION. I UNDERSTAND THAT I AM RESPONSIBLE
FOR ANY DEDUCTIBLE AND COPAYMENTS REQUIRED BY MY
INSURANCE COMPANY(IES). I UNDERSTAND THAT THERE MAY
BE SERVICES PROVIDED THAT ARE CONSIDERED A NON-COVERED,
OR MEDICALLY UNNECESSARY, CHARGE BY MY INSURANCE
COMPANY AND I HEREBY AGREE TO BE FINANCIALLY
RESPONSIBLE FOR SAID CHARGES. I AUTHORIZE THE REFUND OF
ANY OVERPAID INSURANCE BENEFITS. IN THE EVENT OF DEFAULT,
I AGREE TO PAY ALL COSTS OF COLLECTION, INCLUDING ANY
REASONABLE LEGAL FEES.

SIGNATURE _____

DATE _____

Carolina Nephrology, P.A.

O: 919.580.1026 | F: 919.580.1027 | TF: 877.293.1973

REQUEST FOR RELEASE OF MEDICAL RECORDS



R. David Kemp, M.D.
Ajay I. Shreenath, M.D.
Roopa Shah, M.D.

1704 A Wayne Memorial Dr.
Goldsboro, NC 27534
919.580.1026
F: 919.580.1027

331 North Blvd. Ste. 40
Clinton, NC 28328
919.580.1026
F: 919.580.1027

DATE _____

TO _____

I HEREBY REQUEST THAT MY MEDICAL RECORDS BE RELEASED TO:

**CAROLINA NEPHROLOGY, P.A.
1704A WAYNE MEMORIAL DR
GOLDSBORO, N.C. 27534
FAX #(919) 580-1027**

PATIENT'S NAME _____

ADDRESS _____

CITY/STATE/ZIP CODE _____

DATE OF BIRTH _____

**THIS AUTHORIZATION EXPIRES ONE YEAR FROM DATE SIGNED.
PATIENT OR LEGAL GUARDIAN MAY CANCEL THIS AUTHORIZATION
AT ANY TIME.**

SIGNATURE _____

(Please sign this form only)