JACKSONVILLE NEPHROLOGY
Kidney Diseases and Hypertension

Annual Chart Review

Patient Information		
Name (First, Middle, Last)	DOB	Birth Gender ☐ Male ☐ Female
Mailing Address	City, State, Zip	
Home Phone	Cell Phone	Preferred contact for appointment reminders? ☐ Home ☐ Cell
Employer Name	Marital Status ☐Widow/Widower ☐Single ☐Married ☐Divorced ☐Partner	Work Phone
Primary Care Provider		☐No PCP
Preferred Language	Race: ☐Asian ☐American Indian ☐Black or African American ☐Native Hawaiian/Pacific Islander ☐White ☐Other ☐Prefer not to answer	
Ethnicity ☐Hispanic/Latino ☐ Not Hispanic/Latino		

Patient Portal

Our Patient Portal provides you access to your medical records 24/7. You can view results, request prescription refills, connect a health tracker device, pay a balance and schedule your next appointment. To activate, provide a non-work email address.

Non-work Email Address: «Email»

Emergency Contact Best person to contact in case of emergency. No medical information released to this individual.		
Contact Name	Phone Number	Relationship to Patient

Preferred Pharmacy	
Pharmacy Name	Pharmacy Location

Medical Insurance (Please present your ID and insurance card to the Front Desk)		
PRIMARY Insurance Carrier Name	Policy Number/Member ID	Group Number
Insured Name	Insured DOB	Patient Relationship to Insured ☐ Self ☐Spouse ☐ Dependent
Insurance Carrier Address		Phone
SECONDARY Insurance Carrier Name	Policy Number/Member ID	Group Number
Insured Name	Insured DOB	Patient Relationship to Insured ☐ Self ☐Spouse ☐ Dependent
Insurance Carrier Address		Phone

JACKSONVILLE NEPHROLOGY
Kidney Diseases and Hypertension

Annual Chart Review

TEXT MESSAGE ALERTS

I authorize Jacksonville Nephrology to send SMS text message alert reminders on my provided cell phone number. I understand that I may receive alerts regarding appointment reminders, check in completion, missed appointment notifications, account balance or other similar messages. By accepting these terms, I acknowledge ownership of the listed cell phone number and in the event that my cell phone number changes I will inform Jacksonville Nephrology immediately. Text message rates may apply.

Privacy disclaimer: ***Text messaging is provided as a service. Your information will not be shared or distributed in any way.***

Signature of Patient:_____Date:_____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO YOUR FAMILY OR OTHER INDIVIDUALS

In accordance with the federal government privacy rules implemented through the Health Insurance Portability and Accountability Act (HIPAA) of 1966, in order for your physician or the staff at Jacksonville Nephrology PA to give copies of and/or discuss your condition/exam/procedures/results with members of your family or other individuals that you designate other than your primary care doctor or specialist, we must obtain your authorization prior to doing so.

I authorize Jacksonville Nephrology PA to release any and all information (including verbal information, copies of results, appointment information) concerning my medical care to the following individual(s):

☐ You may release medical information as described above to my listed **Emergency Contact**.

☐ I DO NOT authorize Jacksonville Nephrology PA to release any information concerning my care to any individual.

Name:_____Relationship:_____

Phone Number:_____

Name: _____Relationship:_____

Phone Number:_____

Printed Patient Name:_____

Signature of Patient or Parent/Guardian:_____Date:_____