Today's Date: ____________________ **If applicable start date of your Dialysis**: ________________________

PATIENT'S NAME: ____
Patient's name as it appears on your insurance card. All records will appear with that name.

ADDRESS: ____ CITY: ________________ ZIP: ____________

PHONE #: _______________________________ ALTERNATE PHONE #: _____________________________________

E-MAIL ADDRESS: ____

SEX: MALE / FEMALE MARTIAL STATUS: MARRIED / SINGLE / WIDOWED / DIVORCED / SEPARATED

SOCIAL SECURITY # ____________________________
DATE OF BIRTH: ________________________________

PATIENT'S EMPLOYER: ____
ADDRESS: ____
PHONE: ____

SPOUSE NAME: ____
SPOUSE DATE OF BIRTH: ____

PRIMARY PHYSICIAN: ____
ADDRESS: ____
PHONE: ____

REFERRING PHYSICIAN: ____
PHONE #: ____

NAME OF DIALYSIS CENTER: ______________________________________
(If applicable)
ADDRESS: ____
PHONE #: ____

EMERGENCY CONTACT:
NAME: ____
PHONE #: ____
RELATIONSHIP: ____

PATIENT'S SIGNATURE: ____DATE: __________________________

OFFICE STAFF SIGNATURE: _______________________________________ DATE: __________________________

I HEREBY INSTRUCT AND DIRECT MY INSURANCE COMPANY THAT ALL CHECKS FOR MY MEDICAL SERVICES PROVIDED BY KEVIN D. NOLAN, M.D. AND/OR WILLIAM F. OPPAT, M.D. AND/OR TAMER N. BOULES, M.D. AND/OR PRITHAM P. REDDY, M.D. BE PAYABLE AND MAILED TO:

COMPREHENSIVE VASCULAR CARE
22250 PROVIDENCE DRIVE, SUITE 555
SOUTHFIELD, MI 48075

A PHOTOCOPY OF THIS ASSIGNMENT SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL. I AUTHORIZE DR. NOLAN AND/OR DR. OPPAT AND/OR DR. BOULES AND/OR DR. REDDY TO INITIATE A COMPLAINT TO THE INSURANCE COMMISSONER FOR ANY REASON ON MY BEHALF.

I UNDERSTAND AND AGREE THAT (REGARDLESS OF MY INSURANCE STATUS) I AM ULTIMATELY RESPONSIBLE FOR THE BALANCE OF MY ACCOUNT FOR ALL PROFESSIONAL SERVICES RENDERED. I HEREBY AUTHORIZE PAYMENT TO COMPRHENSIVE VASUCLAR CARE, P.C. FOR SURGICAL AND/OR MEDICAL BENEFITS. I HAVE READ AND COMPLETED ALL THE INFORMATION ON THIS FORM. I CERTIFY THAT THE ABOVE IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I WILL NOTIFY THE OFFICE OF ANY CHANGES IN MY STATUS ON THE ABOVE INFORMATION.