Southeastern Nephrology Associates
Contact/Communication Form

Patient Name _____

Date of Birth: _____/_____/_____ **Patient SSN:** _____-_____-_____

Sex: M / F **Race** _____ **Ethnicity**_____ **Marital Status** _____

Home Phone_____ **Cell Phone**_____

Work Phone_____ **E-mail** _____

Mailing/Billing Address_____

_____

Is there any other person allowed to discuss or receive your protected health information?

Yes_____ **(such as family members, or friends) No**_____

1. Name_____ **Relationship to patient**_____

Contact number 1. _____ **Contact number 2.** _____

Mailing Address_____

2. Name_____ **Relationship to patient**_____

Contact number 1._____ **Contact number 2.** _____

Mailing Address_____

3. Name_____ **Relationship to patient**_____

Contact number 1. _____**Contact number 2.** _____

Mailing Address_____

_____

PATIENT SIGNATURE:_____ **DATE:**_____