

Georgia Kidney Associates

Patient Registration Form

Patient Name: _____ M/ F Date: ___/___/___
(First) (MI) (Last) (Sex)

Home Address: _____
(Street / Number) (City) (State) (ZIP)

Home Phone: (____) - _____ Date of Birth: ___/___/___ Age: ____ Marital Status: ____

SSN: ___/___/___ Known Allergies: _____

Patient's Employer: _____ Phone Number: (____) - _____

Address: _____
(Street / Number) (City) (State) (ZIP)

Spouse's or Parent's Name: _____ SSN: ___/___/___

Spouse's or Parent's Employer: _____ Phone Number: (____) - _____

Address: _____
(Street / Number) (City) (State) (ZIP)

Next of Kin/Nearest Relative/Friend: _____ Phone Number: (____) - _____

Address: _____
(Street / Number) (City) (State) (ZIP)

*****INSURANCE INFORMATION*****

Medicare Number _____ Medicaid Number _____

Insurance Company #1 _____ Group Name _____

Address: _____
(Street / Number) (City) (State) (ZIP)

Insured: _____ I.D. Number: _____ Policy Number: _____

Insurance Company #2 _____ Group Name _____

Address: _____
(Street / Number) (City) (State) (ZIP)

Insured: _____ I.D. Number: _____ Policy Number: _____

Referred by: _____

I authorize any physician, hospital, or clinic to provide full details of my medical history and treatment to Dr. Himot, Dr. Chervu, Dr. Jansen, Dr. Ogundipe, Dr. Nath or Dr. Jaglan. I also authorize Dr. Himot, Dr. Chervu, Dr. Jansen, Dr. Ogundipe, Dr. Nath or Dr. Jaglan to furnish my insurance company any information they may request regarding my present illness or injury.

I hereby assign payment directly to **GEORGIA KIDNEY ASSOCIATES, INC.** the amount now due for medical expenses incurred and payable under terms of my basic insurance as well as Major Medical benefits. I understand that I am financially responsible for any charges not covered by this assignment. **PHOTOCOPIES OF THIS FORM WILL BE VALID.**

Signature of Patient/Parent

(Date)