Georgia Kidney Associates

Edward D. Himot, M.D., Indira Chervu, M.D., F.A.C.P., Akin Ogundipe, M.D.
Vijay Nath, M.D., Sandeep Jaglan, M.D., Samuel Johnson, M.D., Kimone James, M.D. Samantha Suthar, M.D., Ashvin, Kamath, M.D.

Patient Information Sheet

Patient Name: _____ **Date of Birth:** _____
Height: _____ **Referring Physician:** _____
Reason for Referral: _____

Local Pharmacy Name: _____ **Address/ Phone:** _____
Mail Order Pharmacy Name: _____ _____

Medications:

Name:	Dosage:	Frequency:

Allergies:	Reactions:

Health Maintainence:	Immunizations:
Colonscopy:	**Flu Shot:**
Vision Screening:	**Pneumonia:**
Bone Density:	**Tetanus:**
Hemoglobin A1C:	**Shingles:**
Pap/Pelvic:	
Breast Exam:	
Mammogram:	

Any further information which you believe is important may be provided in the space below.

_____
_____
_____
_____

PATIENT REGISTRATION FORM

PATIENT'S NAME:_____ M/F_____ DATE:_____
(First) (MI) (Last) (Sex)

HOME ADDRESS:_____ CITY:_____ STATE:_____ ZIP:_____

HOME PHONE:_____ DATE OF BIRTH:_____ AGE:_____ MARITAL STATUS:_____

SOCIAL SECURITY NUMBER:_____ KNOWN ALLERGIES:_____

PATIENT"S EMPLOYER:_____ PHONE NUMBER:_____

ADDRESS:_____ CITY:_____ STATE:_____ ZIP:_____

SPOUSE'S OR PARENT'S NAME:_____ SOCIAL SECURITY NUMBER:_____

SPOUSE'S OR PARENT'S EMPLOYER:_____ PHONE NUMBER:_____

ADDRESS:_____ CITY:_____ STATE:_____ ZIP:_____

NEXT OF KIN/NEAREST RELATIVE OR FRIEND:_____ PHONE NUMBER:_____

ADDRESS:_____ CITY:_____ STATE:_____ ZIP:_____

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

MEDICARE NUMBER: _____ MEDICAID:_____

INSURANCE COMPANY #1:_____ GROUP NAME:_____

ADDRESS:_____ CITY:_____ STATE:_____ ZIP:_____

INSURED:_____ I.D. NUMBER:_____ POLICY NUMBER:_____

INSURANCE COMPANY #2:_____ GROUP NAME:_____

ADDRESS:_____ CITY:_____ STATE:_____ ZIP:_____

INSURED:_____ I.D. NUMBER:_____ POLICY NUMBER:_____

REFERRED BY:_____

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

I authorize Georgia Kidney Associates, Edward D. Himot, MD; Indira Chervu, MD; Akin O. Ogundipe, MD; Vijay Nath, MD; Sandeep Jaglan, MD; Kimone James, MD; Samuel A. Johnson, MD; Samantha D. Suthar, MD; Renée Figueroa, ANP-BC; Trang Nguyen, NP-C; ACCNS-AG, NP-C; Alexandra Diluzio, PA-C; Angela Berndt, ACNP-BC; Jessica Brown, NP-C; and any other affiliated professionals to render medical care and treatment to me.

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 INVALID.**

DATE:_____ SIGNATURE OF PATIENT/PARENT:_____

GEORGIA KIDNEY ASSOCIATES, INC.

PATIENT CONFIDENTIALITY FORM

TO ENSURE THAT THERE IS NO VIOLATION OF YOUR PRIVACY, PLEASE PROVIDE US WITH THE FOLLOWING INFORMATION:

In the event that I, _____, cannot be reached, Georgia Kidney Associates, Inc. may leave any test result, lab result, appointment information or other confidential medical information with the following:

Please circle all that apply:

Spouse	Name:	_____	Number:	_____
Children	Name:	_____	Number:	_____
	Name:	_____	Number:	_____
	Name:	_____	Number:	_____
Home Voice Mail:			Number:	_____
Work Voice Mail:			Number:	_____
Cell Voice Mail:			Number:	_____
Other	Name:	_____	Number:	_____
	Name:	_____	Number:	_____

If there is anyone you ***DO NOT*** wish us to discuss this information wish, please specify below.

_____

_____

_____

_____ _____

PATIENT SIGNATURE DATE