

Kidney Clinic

1425 Highway 34 East
Newnan, GA 30265
Tel: 770-304-3724 Fax: 770-304-3726

106 Governors Square, Suite A
Peachtree City, GA 30269
Tel: 770-376-6256 Fax: 678-545-6872

PATIENT INFORMATION

Name: Last _____ First _____ MI _____
Sex (circle one): M F Social Security # _____ - _____ - _____ DOB: _____
Address _____
City _____ State _____ Zip _____
Home phone _____ Cell _____ Email: _____
Marital Status (circle one): Married Single Divorced Widowed
Race (circle one): African American Asian/Pacific Islander Hispanic White Other
Employer _____ Work Phone _____
Primary Care Physician _____ Phone # _____

RESPONSIBLE PARTY INFORMATION (if different from above)

Guarantor Name _____ Relationship to patient _____
Social Security # _____ - _____ - _____ Guarantor Date of Birth ____/____/____
Guarantor Address (if different than above) _____
City _____ State _____ Zip _____

EMERGENCY/CONTACT PERSON

Name _____ Relationship _____
Phone Home _____ Work _____ Cell _____

PRIMARY INSURANCE INFORMATION

Company Name _____ Patient Relationship to Insured _____
Policy Holder Name _____ Insurance ID# _____
Policy Holder Date of Birth ____/____/____ Policy Holder Social Security # ____ - ____ - ____

SECONDARY INSURANCE INFORMATION

Company Name _____ Patient Relationship to Insured _____
Policy Holder Name _____ Insurance ID# _____
Policy Holder Date of Birth ____/____/____ Policy Holder Social Security # ____ - ____ - ____

GUARANTEE OF PAYMENT: The undersigned agrees to pay all co-pays, coinsurance, deductibles, and charges not covered by the insurance carrier. Should an account be referred to an attorney or a collection agency, the undersigned agrees to pay reasonable attorney's fees, court cost, and collection expenses.

AUTHORIZATION TO RELEASE INFORMATION: (Insurance Carriers)
I hereby authorize the physician/physician office to release any information acquired in the course of my examination and treatment to my Insurance Carriers.

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN:
I hereby authorize payment directly to Kidney Clinic of all medical benefits otherwise payable to me for services rendered.

Signature of Insured/Guarantor _____ Date ____/____/____