Hypertension and Kidney Care of North Atlanta, LLC
REGISTRATION FORM

Today's date ___/____/_____ PCP _____

PATIENT INFORMATION

¡ Mr.¡ Mrs. ¡ Miss Patient last name	First	Middle		Marital Status (circle one) Single/ Mar / Div/ Sep/ Wid
Is this your legal name? ¡ yes ¡ No	Former name	Age	Birth Date __/__/___	Sex ¡ male ¡ female
Street Address/PO Box	City ST	Zip	Social Security ___/___/_____	Home phone#___/___/_____ Cell phone# ___/___/_____
Occupation	Employer			Work phone #
Referred by/choose clinic ¡ Family ¡ friend ¡ Dr. _____	*(please check)* ¡ Close to home/work #_____	¡ other	¡yellow book	Is the patient covered by insurance?¡ yes ¡ No
Other family member seen				Phone #

INSURANCE INFORMATION ***(PLEASE GIVE YOU INSURANCE CARD TO THE RECEPTIONIST)***

Subscriber's Name	Social Security ___/___/_____		Birth Date __/__/___	Relationship to Subscriber's ¡ self ¡ spouse ¡ Child
Insurance Name	Group #	Policy#	Effective date	Deductible _____ Co payment $ _____
Street Address/PO Box	City ST	Zip		Work phone #
Secondary insurance				Relationship to Subscriber's ¡ self ¡ spouse ¡ Child
Insurance Address	Group #	Policy		Deductible _____ Co payment $ _____
Referral needed				

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address)	Relationship to Patient	Home Phone #	Work phone #

The above information is true to the best of my knowledge, I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also Authorize Hypertension and Kidney Care of North Atlanta, LLC or insurance company to release any information required to process my claim.

X _____
Patient/Guardian Signature Date