GEORGIA RENAL ASSOCIATES, PC
PATIENT REGISTRATION FORM

(Please Print)

Today's date:	PCP:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F

Race:	Ethnicity:	Preferred Language:
Street address:	Social Security no.:	Home phone no.: ( )

P.O. box:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.: ( )

Chose clinic because/Referred to clinic by (please check one box): ❑ Dr. __________ ❑ Insurance Plan ❑ Hospital
❑ Family ❑ Friend ❑ Close to home/work ❑ Yellow Pages ❑ Other

Other family members seen here:

INSURANCE INFORMATION

******Please give us your insurance card to the receptionist******

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Is this person a patient here? ❑ Yes ❑ No

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

Patient/Guardian signature ***Date***

GEORGIA RENAL ASSOCIATES, PC
PATIENT AUTHORIZATIONS

| GEORGIA RENAL ASSOCIATES

Patient Name: ______________________ Date of Birth: ______________

- I hereby authorize and request the medical treatment necessary for the care of the above named patient.
- I authorize the release of all medical records and appeals to the referring and family physicians and to my Insurance Company, if applicable. I allow the fax transmittal of my records, if necessary.
- I acknowledge full financial responsibility for services rendered by Georgia Renal Associates, PC. I understand payment is due at the time of service unless other definite financial arrangements have been made prior to treatment. I understand that I am responsible for any un-met deductibles and co-insurance fees.
- I understand that insurance companies have certain agreements with certain laboratories for la b work and that It Is my responsibility to know which laboratory my insurance authorizes and to Inform the staff of Georgia Renal Associates, PC as to which laboratory my Insurance covers,
- I further authorize and request that insurance payments be made directly to Georgia Renal Associates, PC for services rendered.
- I have read and fully understand the above consent for treatment, release of medical Information, financial responsibility and insurance authorization.

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 Georgia Renal Associates, PC or insurance company to release any information required to process my claims.

______________________ ______________

Patient/Guardian signature *Date*