Kidney Clinic

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

130 Governors Square, Suite C
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____/____/____