# Georgia Renal & Hypertension Care

## PATIENT INFORMATION

DATE_____ SOCIAL SECURITY #_____

NAME_____

ADDRESS_____

CITY_____ STATE_____ ZIP_____

HOME PHONE._____ CELL PHONE._____

SEX M F AGE_____ BIRTIIDATE_____ SINGLE MARRIED WIDOWED DIVORCED

PATIENT EMPLOYER/ SCHOOL_____ OCCUPATION_____

EMPLOYER/SCHOOL ADDRESS_____ PHONE_____

WHO MAY WE THANK FOR REFERRING YOU?_____

EMERGENCY CONTACT NAME_____ RELATION_____ PHONE_____

## INSURANCE INFORMATION PRIMARY

### INSURANCE

PERSON RESPONIBLE FOR ACCOUNT_____ RELATION TO PT_____

INSURANCE COMPANY_____

CONTRACT/ID NUMBER_____ GROUP NUMBER_____

SECONDARY INSURANCE (IFAPPLICABLE)

SUBSCRIBERNAME_____ RELATIONTO PATIENT_____

INSURANCE COMPANY_____

CONTRACT/ IDNUMBER_____ GROUP Number _____

I CERTIFY THAT I AND/OR MY DEPENDENT(S) HAVE INSURANCE COVERAGE WITH_____ AND ASSIGN DIRECTLY TO DR. _____ ALL INSURANCE BENEFITS. IF ANY OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED. I UNDERSTAND THAT I AM FINACIALLY RESPONSIBLE FOR ALLCHARGES WHETHER OR NOT PAID BY INSURANCE. I AUTHORIZE THE USE OF MY SIGNATURE ON ALL INSURANCE SUBMISSIONS. THE ABOVED-NAMED DOCTOR(S) MAY USE MY HEALTH CARE INFORMATION AND MAY DISCLOSE SUCH INFORMATION TO THE ABOVE- NAMED INSURANCE COMPANY(IES) AND THEIR AGENTS FOR THE PURPOSE OF OBTAINING PAYMENT FOR SERVICES AND DETERMINING INSURANCE BENEFITS OR THE BENEFITS OR THE BENEFITS PAYABLE FOR RELATED SERVICES. CONSENT WILL END WHEN MY CURRENT TREATMENT PLAN IS COMPLETED OR ONE YEAR FROM THE DATE SIGNED BELOW.

_____ _____

SIGNATURE OF PATIENT, PARENT, GUARDIAN OR PERSONAL REPRESENTATIVE DATE

_____ _____

PRINT NAME OF PATIENT, PARENT, GUARDIAN OR PERSONAL REPRESENTATIVE RELATIONSHIP TO PATIENT