midtown atlanta nephrology, p.c.

PATIENT REGISTRATION FORM
(Please Print)

Appointment Date _____/_____/_____

Name: _____ Preferred Name: _____
(last) (first) (MI)

SSN: _____ Date of Birth: _____/_____/_____ Age: _____ Sex: ☐Male ☐Female

Address: _____ City/St/Zip: _____

Home Phone: _____ Cell Phone: _____ Preferred contact: ☐Home ☐Cell

Marital Status: ☐Single ☐Married ☐Separated ☐Divorced ☐Widowed Race: _____

Email Address: _____ Language: _____

Primary Care Physician: _____ Phone #: _____

Referring Physician: _____ Phone #: _____

Emergency Contact: _____ Relationship: _____ Phone #: _____

Employer: _____ Employer Phone: _____

Address: _____ City/St/Zip: _____

Please present your Driver's License and Insurance card(s) to the receptionist. If you are unable to provide these you may be considered a self paying patient.

Primary Insurance: _____ ID #: _____ Group #: _____
Subscriber: _____ Subscriber Date of Birth: _____/_____/_____

Secondary Insurance: _____ ID #: _____ Group #: _____
Subscriber: _____ Subscriber Date of Birth: _____/_____/_____

Please initial applicable statements below:

_____ I give permission for voice mail messages to be left at my home. The message can include the nature of the call, but not specific information.
_____ I give permission to call me on my cell phone.
_____ I give permission for my medical and billing information to be discussed with _____ and _____.
_____ I have received the notice of privacy practices.

I have reviewed the above information, and to the best of my knowledge it is correct and complete.

_____ _____
Signature Date