KIDNEY AND HYPERTENSION CONSULTANTS, INC.
4689 Fulton Drive N.W., Canton, Ohio 44718
(330) 649-9400

PATIENT REGISTRATION

APPOINTMENT DATE: _____

DOCTOR: _____

PLEASE PRINT

PATIENT INFORMATION

LAST NAME OF PATIENT	FIRST	MI	HOW DO YOU PREFER TO BE ADDRESSED (NICKNAME)?
ADDRESS			

CITY	STATE	ZIP CODE	SEX	HOME PHONE	DATE OF BIRTH

SOCIAL SECURITY NO.	AGE	MARITAL STATUS	DRIVER'S LICENSE #
		___ SINGLE ___ MARRIED ___OTHER	

EMPLOYER	ADDRESS	CITY	STATE	ZIP CODE	TELEPHONE

SPOUSE

SPOUSE'S NAME	ADDRESS	SOCIAL SECURITY #	TELEPHONE

SPOUSE'S EMPLOYER	ADDRESS	TELEPHONE

REFERRED BY

NAME	TELEPHONE

ADDRESS

PRIMARY CARE PHYSICIAN	TELEPHONE

REASON YOU WERE REFERRED

NOTIFY IN CASE OF EMERGENCY

NAME	PHONE

You may discuss my medical condition with the following:

1	2

3	4

INSURANCE INFORMATION (Present Insurance Cards to Front Desk)

PRIMARY INSURANCE	SECONDARY INSURANCE
INSURANCE CARRIER	INSURANCE CARRIER
INSURED NAME	INSURED NAME
INSURED DOB	INSURED DOB
ID#	ID#

RECORDS RELEASE: I hereby authorize the release of any information, including medical and billing information to my referring doctor and my insurance company. I understand that you may be transmitting my medical records electronically and authorize you to do so. If another party in error receives them, I absolve Kidney and Hypertension Consultants, Inc. of any and all liability to such submission of said records.

GUARANTEE OF ACCOUNT: I understand that medical insurance policies are an arrangement between an insurance carrier and myself. I understand I am financially responsible for any balance not covered by my insurance company. I understand that I am responsible for any co-payments, deductibles and fees for non-covered services. I understand I am responsible for any referrals and/or authorizations required by my insurance company.

ASSIGNMENT OF BENEFITS: I hereby authorize Medicare benefits and other insurance benefits to be paid on my behalf to KIDNEY AND HYPERTENSION CONSULTANTS, INC., for any services furnished me by that physician/clinic/supervisor. I authorize any holder of hospital or medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I permit a copy of this authorization to be used in place of the original.

Signature: _____ Date: _____