Kidney Associates Inc
Registration Form

(Please Print)

Today Date:		Primary Care Provider:			
Patient Information					
Patient last name: First: Middle:		☐ Mr. ☐ Mrs.	☐ Miss. ☐ Ms.	Marital status (circle one) Single / Mar / Div / Wid	
Is this your legal name? ☐ yes ☐ no	If not, what is your legal name?	Former name:	Birth date: / /	Age:	Sex: ☐ M ☐ F
Street Address:		Social Security no:		Phone Number:	
P.O. Box no:	City:	State:		Zip Code:	
Occupation:	Employer:	Employer Phone no:			
Chose Clinic because/Referred to clinic by(please check one box):	☐ Dr.	☐ Insurance plane	☐ Hospital		
☐ Family	☐ Friend	☐ Close to home/work	☐ Yellow Pages	☐ Other	
Other family member seen here:					

INSURANCE INFORMATION					
(Please give 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 person a patient covered by insurance ? ☐ Yes ☐ No					
Please indicate primary insurance:	☐ Medicare	☐ Medicaid	☐ Aetna	☐ Blue Cross	☐ Cigna
☐ UHC:	☐ Care Improvement:	☐	☐	☐ Other	
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:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to Kidney Associates Inc. I understand that i am financially responsible for any balance. I also authorize Kidney Associates and Insurance company to release any information required to process my claims.

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Patient/Guardian signature **Date:**