KIDNEY HYPERTENSION TRANSPLANT SPECIALISTS

NEW PATIENT REGISTRATION

Please print clearly so that we can process your information quickly and efficiently. Thank you!

Legal Name (*First, M.I., Last*)______________________________

Date of Birth __________ Age __________ Male / Female Marital Status: S M W D

Address ______________________________

Phone __________ Driver License #__________ Social Security No. __________

Employer ____________________ Phone __________

Employer Address ______________________________

Referring Physician ____________________ Hospital __________

If Student, School Name ____________________ Full-Time / Part-Time

Responsible Party

Name ____________________ Relationship to Patient __________

Address______________________________

Phone __________

Employer ____________________ Phone __________

Employer Address______________________________

Emergency Contact ____________________ Phone __________

Insurance Information

Insurance Company ____________________ Phone__________

Address ______________________________

Group # __________ Certificate/ID # __________ Plan: HMO / PPO / POS / REPLACEMENT

Insured's Name ____________________ Relationship to Patient: Self / Spouse / Dependent

Insured's Employer ____________________ Phone __________

Employer Address______________________________

Date of Birth __________ Male / Female

I hereby assign, transfer, and set over to Kidney Hypertension & Transplant Specialist all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization will remain valid until I revoke it by written notice. I understand that I am financially responsible for all charges whether or not they are covered by insurance.

Patient Signature ____________________ Date __________