# Mid-Atlantic Kidney Centers
# Patient Registration

Date: _____ Referring Physician: _____

| | | | | |
|---|---|---|---|---|
| Name: (Last) | (First) | | | (MI) |
| Street Address: | | | | DOB: |
| City: | State: | Zip: | Home Phone: | Work Phone: |
| Social Security #: | Sex: (Circle) M F | Marital Status (Circle): Married Single Divorced Widowed | | Employer: |
| Ethnicity: | Race: | Primary Language: | | Email Address: |
| INSURANCE INFORMATION: Allergies: | | | | |
| Primary Insurance Company: | | | | Relationship to Patient: |
| Policy #: | | Group #: | | |
| Secondary Insurance Company: | | | | Relationship to Parent: |
| Policy #: | | Group #: | | |

I authorize Mid-Atlantic Kidney Centers to share pertinent information including medical information with the following people.

| Name | Relationship to Patient | Name | Relationship to Patient |
|---|---|---|---|
| Name | Relationship to Patient | Name | Relationship to Patient |

I hereby authorize Mid-Atlantic Kidney Centers to release all pertinent information requested to my insurance company, attorney, legal representative or personal representative. I authorize payment directly to Mid-Atlantic Kidney Centers of benefits otherwise payable to me. I understand that I am financially responsible for the charges not covered by this authorization. I agree that in the event my account must be turned over to an attorney or agency for collection, I will be responsible for the attorney's fees, collection fees, court costs and interest.

I hereby authorize release of all pertinent information to Mid-Atlantic Kidney Centers requested by Mid-Atlantic Kidney Centers.

Patient Signature: _____ Date: _____

Guarantor Signature: _____ Date: _____

I acknowledge that I have received the Notice of Privacy Practices from Mid-Atlantic Kidney Centers.

Patient Signature: _____ Date: _____