Augusta Renal Physicians, P.C.
Internal Medicine – Nephrology
1109 Medical Center Drive, Bldg 5
Augusta, Georgia 30909

Telephone: (706) 863-6637
Fax: (706) 863-6638

Michael L. Whitlow, MD
Nadeem Afzal, MD, MRCP (UK), FASN

CHART # _____ PROVIDER _____

PATIENT INFORMATION

PATIENT NAME: _____ SEX: _____
LAST FIRST MIDDLE

ADDRESS: _____ CITY: _____ STATE: _____ ZIP CODE: _____

HOME PHONE #: _____ DATE OF BIRTH: _____

WORK PHONE #: _____ SOCIAL SECURITY NUMBER: _____

CELL/OTHER: _____ REFERRED BY: _____

E-MAIL ADDRESS: _____

MARITAL STATUS: _____ SPOUSE'S NAME: _____

PREFERRED LANGUAGE: _____ ETHNICITY & RACE: _____

PATIENT'S EMPLOYER: _____ PHONE #: _____

EMERGENCY CONTACT: _____ PHONE: _____

RESPONSIBLE AND/OR SUBSCRIBER INFORMATION

NAME: _____ SEX: _____
LAST FIRST MIDDLE

ADDRESS: _____ CITY: _____ STATE: _____ ZIP CODE: _____

RELATIONSHIP TO PATIENT: _____ DATE OF BIRTH: _____

HOME PHONE #: _____ SOCIAL SECURITY NUMBER: _____

RESPONSIBLE PARTY'S EMPLOYER: COMPANY: _____ PHONE #: _____

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY: _____ SUBSCRIBER'S NAME: _____

ADDRESS: _____ SUBSCRIBER'S DATE OF BIRTH: _____

PHONE: _____ GROUP NAME: _____

MEMBER ID NUMBER: _____ GROUP NUMBER: _____

PATIENT RELATIONSHIP TO SUBSCRIBER: _____

SECONDARY INSURANCE COMPANY: _____ SUBSCRIBER'S NAME: _____

ADDRESS: _____ SUBSCRIBER'S DATE OF BIRTH: _____

PHONE: _____ GROUP NAME: _____

MEMBER ID NUMBER: _____ GROUP NUMBER: _____

PATIENT RELATIONSHIP TO SUBSCRIBER: _____

CHART #

PATIENT HISTORY

IS THIS VISIT A RESULT OF A WORK INJURY? ☐YES ☑NO DATE OF INJURY:_____

INDUSTRIAL CLAIM #_____

IS THIS VISIT A RESULT OF A CAR ACCIDENT? ☐YES ☑NO DATE OF ACCIDENT:_____

ATTORNEY:_____

HOW LONG EMPLOYED AT CURRENT POSITION? _____

DRUG ALLERGY? (PLEASE LIST)_____

_____

WHO CAN WE THANK FOR REFERRING YOU TO OUR PRACTICE?_____

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I have been presented with a copy of the Augusta Renal Physicians, P.C., Notice of Privacy Policies, detailing how my information may be used and disclosed as permitted under Federal and State law. I understand the contents of this notice .

Further, I permit a copy of this authorization to be used to request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to medical assignment of benefits apply.

_____ _____

SIGNATURE **DATE**

If not signed by patient, please indicate relationship to patient (e.g. spouse)

_____ _____

RELATIONSHIP WITNESSED BY

INTERNAL USE ONLY

If patient or patient's representative refuses to sign acknowledgement of receipt of notice, please document the date and time the notice was presented to patient and sign below.

_____ _____

PRESENTED ON (DATE & TIME) BY: (NAME & TITLE)