

# SOUTHWEST ATLANTA NEPHROLOGY

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## NEW PATIENT DEMOGRAPHIC FORM

Name \_\_\_\_\_ Marital Status \_\_\_\_\_

Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

SS # \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_ Male / Female \_\_\_\_\_

Home Phone (\_\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_\_) \_\_\_\_\_ Ext. \_\_\_\_\_

Employer \_\_\_\_\_ Work Status: Full Part-time Retired Unemployed

Referring Physician \_\_\_\_\_ Phone # (\_\_\_\_\_) \_\_\_\_\_

In the event of an EMERGENCY who would you like for us to contact? Name \_\_\_\_\_

Relationship \_\_\_\_\_ Phone # (\_\_\_\_\_) \_\_\_\_\_

## INSURANCE INFORMATION

Primary Insurance Co. \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_

Claims Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Insured's Name \_\_\_\_\_ D.O.B. \_\_\_\_\_ Effective Date \_\_\_\_\_

Policy / ID # \_\_\_\_\_ Group # \_\_\_\_\_ Co-pay / % \_\_\_\_\_

Secondary Insurance Co. \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_

Claims Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Insured's Name \_\_\_\_\_ D.O.B. \_\_\_\_\_ Effective Date \_\_\_\_\_

Policy / ID # \_\_\_\_\_ Group # \_\_\_\_\_ Co-pay / % \_\_\_\_\_

I hereby authorize Southwest Atlanta Nephrology to release by mail or electronically, any information needed by my Insurance Carrier to process claims for payment. I also authorize my Insurance Carrier to forward payment(s) for Medical and/or Surgical benefits to the Physician(s), i.e. provider of service with Southwest Atlanta Nephrology. I understand that I am financially responsible for all services rendered to me whether they are or are not covered by my Insurance.

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

7/9/2009