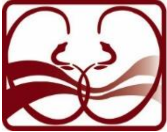

ADULT HYPERTENSION & KIDNEY SPECIALISTS, LLC

Pius Kurian, MD, FACP, FASN, FASH
2200 North Limestone St
Suite 114
Springfield, Ohio 45503
937-322-7364 (Phone)
937-322-3800 (Fax)

Patient Registration Form

First Name_____________________________MI_________ Last Name___________________DOB__________

Address____City____________________State____Zip____________

Home Phone_____________________Cell Phone____________________Work Phone____________________

SS#_______-________-__________ Sex: M F Email Address____

Ethnicity: (circle one) American Indian, Alaskan Native, Black/African American, Bi-Racial, White/Caucasian, Middle Eastern, Hawaiian/Pacific Islander, Unknown/Other

Employed: Y/N PT/FT Employer:________________________________Address:_______________________________

Marital Status: M S D W Sep SO Spouse Name_________________________________Spouse DOB__________

Do you have a Living Will? Yes No Preferred Language___________________________

Emergency Contact: Name__________________________Relationship______________Phone___________________

If patient in NOT the subscriber (carrier of insurance) please provide the following:

Primary Insurance:_________________________Subscriber Name:__________________Relationship:________________

DOB:_______________ Employed: Y/N PT/FT Subscriber Name of Employer:_____________________________________

Secondary Insurance:________________________Subscriber Name:_________________Relationship:________________

DOB:_______________ Employed: Y/N PT/FT Subscriber Name of Employer:___________________________________

Primary Care Physician:________________________Address:______________________________Phone:______________

Referring Physician: (if applicable)____Phone:______________

Please read and initial each line. If you have questions, please ask/call for assistance.

1. _____ I have given the office my current and correct insurance information.
2. _____ I understand that I could be charged $30 for missed appointments if 24hr notice is not given.
3. _____ I understand that I could possibly be discharged from the practice for multiple missed appointments.
4. _____ I understand that my co-payment is due at each visit.
5. _____ I understand that I may be responsible for charges related to the completion of forms and letters.

NOTICE: I attest that the above information is correct to the best of my knowledge. I authorize the release of any medical or other information necessary to process the claim. I also request payment of insurance benefits either to myself or to the party who accept assignment. I authorize payment of insurance benefits to the physician or supplier for all services rendered. I also understand and agree that regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered or fees associated with my care. I also agree that I am responsible for any collection fees should my account be turned over to a collection agency.

Signature of Responsible Person____Date______________