



86 Upper Riverdale Road
Riverdale, GA 30274

(678)902-0222 / Voice

www.kunkesent.com

New Patient Registration Form

Name: _____ Patient ID#: _____ Male Female
 Address: _____ Date of Birth: ____/____/____ Age: ____
 _____ Social Security #: ____-____-____
 City, State, Zip: _____ Single Married Divorced /Separated
 Home Phone: () - Work: () - Cell: () -
 E-Mail Address: _____

PATIENT EMPLOYMENT

Employed Retired
 Unemployed Other (Student/Minor)
 Employer: _____
 Phone: () -

EMERGENCY CONTACTS

Name: _____
 Phone: () - Relationship: _____
 Name: _____
 Phone: () - Relationship: _____

GUARANTOR

Same as patient
 Name: _____
 Address: _____

 City, State, Zip: _____

EMPLOYMENT

Employer: _____
 Employer Phone: () -
 Guarantor Phone: () -
 Guarantor SSN#: ____-____-____
 Guarantor Date of Birth: ____/____/____

PRIMARY INSURANCE

Same as Patient Same as Guarantor
 Other
 Insured: _____
 Insured: _____
 Company: _____

Relationship to Patient: _____
 Social Security #: ____-____-____
 Insured's ID #: _____
 Policy Group #: _____
 Insured's Date of Birth: ____/____/____

SECONDARY INSURANCE

Same as Patient Same as Guarantor
 Other
 Insured: _____
 Insured: _____
 Company: _____

Relationship to Patient: _____
 Social Security #: ____-____-____
 Insured's ID #: _____
 Policy Group #: _____
 Insured's Date of Birth: ____/____/____



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CURRENT INSURANCE CARD REQUIRED

PLEASE NOTE: Our office **MUST** have a copy of your current insurance card or you will be expected to pay in full at the time of service. Enrollment forms will not be accepted. We will not be able to call for insurance verification at the time of your visit.

Guarantee of Payment for Services & Assignment of Benefits

It is the policy of this office that you must pay for services at the time they are rendered except in the case of surgeries. If you are a surgical patient, we will file your claim for you and you will be responsible for that portion of the bill that is not covered by your insurance. Prior to leaving the office today please be sure to get any questions you may have about this policy answered.

By signing this form you are accepting personal responsibility for payment of all charges in the event that the insurers or guarantor listed on the prior page fail to make prompt payment. In the event that we are forced to place this account with an attorney for collection, you agree to pay all customary and reasonable attorney's fees incurred by this office in the collection of our fees.

I hereby authorize my insurance benefits to be paid directly to my physician and I accept personal responsibility for any non-covered charges. I further authorize my physician to release any information required in order to process this claim and receive payment.

I hereby attest that I have read this document in its entirety and fully understand the information contained herein including but not limited to the guarantee of payment and assignment of benefits as outlined above.

Signature: _____ **Date:** ____/____/____

Name Printed: _____

Relationship to Patient: _____

(If the signatory is not the patient – e.g. parent or guardian)

Witness: _____ **Date:** ____/____/____

Witness Name: _____ **Title:** _____