TEXAS KIDNEY CENTER
caring for your kidneys in a conscientious way

REGISTRATION FORM

Today's date:	Reason for Referral:			
PATIENT INFORMATION				
Last Name:	First Name:	Middle Initial:	Birth Date:	Social Security:
Street address:		City:	State:	Zip:
Home Phone:	Mobile:	Work phone:	Email:	
Gender: ❑Male ❑Female ❑Other	Marital status: ❑Single ❑Married ❑Divorced ❑Separated ❑Widowed		Preferred Method of Contact: ❑Home ❑Mobile ❑Work ❑Patient Portal	
Race: ❑American Indian/Alaskan Native ❑Asian ❑Black/African American ❑Native Hawaiian/Pacific Islander ❑White ❑ Other _____				
Occupation:	Employer:		Employer phone:	
Referred to clinic by: ❑Insurance Plan ❑Hospital _____ ❑Family _____ ❑Friend _____ ❑Internet ❑Other _____				
Primary Care Provider:	Referring Provider:			
Please list Provider(s) to whom the records of your visit are to be sent:				
Pharmacy Name:	Address:		Phone:	
Known Food/ Medication Allergies:				
INSURANCE INFORMATION				
Person responsible for bill:	Birth date:	Address (if different):		Phone:
Is the patient covered by insurance? ❑Yes ❑No	Name of primary insurance:			
Subscriber's name:	Subscriber's SS #:	Birth date:	Policy #:	Group #:	Co-payment: $
Patient's relationship to subscriber (for PRIMARY insurance): ❑Self ❑Spouse ❑Child ❑Other				
Name of secondary insurance (if applicable):	Subscriber's name:	Subscriber's SS#:	Birth date:	Policy #:	Group #:
Patient's relationship to subscriber (for SECONDARY insurance): ❑Self ❑Spouse ❑Child ❑ Other				
DOES YOUR INSURANCE REQUIRE A REFERRAL? ❑ Yes ❑No				
IN CASE OF EMERGENCY				
Name: 1.	Relationship to patient:	Home phone:	Mobile:	Work phone:
2.				

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Texas Kidney Center or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

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