Renal Care Consultants, PC

Patient Information:

Legal Name: _____
Last First Middle

Home Phone: _____ Work Phone: _____

Cell Phone: _____ E-Mail Address: _____

Street Address: _____
Street or PO Box City State Zip

Mailing Address: _____
Street or PO Box City State Zip

Please provide mailing address and street address if they are not the same

Date of Birth: _____ Sex: ☐ Male ☐ Female

Social Security # : _____

Marital Status: ☐ Single ☐ Married Divorced ☐ Widowed

Employer: _____

Occupation: _____

Have you ever received care under another name ? _____

Spouse or Responsible Party:

Legal Name: _____
Last First Middle

Home Phone: _____ Work Phone: _____

Date of Birth: _____ Cell Phone: _____

Employer: _____

Occupation: _____

Emergency Contact Name: _____ Relationship: _____

Contact Phone: _____

Please present your insurance card to the receptionist

Primary Health Insurance:

Company: _____

Mailing Address: _____

Policy Number: _____ Group Number: _____

Insured Name: _____ Relationship to Patient: _____

Secondary Health Insurance:

Company: _____

Mailing Address: _____

Policy Number: _____ Group Number: _____

Insured Name: _____ Relationship to Patient: _____

I am receiving medical treatment as a result of an accident. ☐ Yes ☐ No

If yes, what type of accident? ☐ Motor Vehicle ☐ Work Accident ☐ Other

By signing below, I hereby certify that to the best of my knowledge all the information I have furnished on this form is complete, true and accurate.

_____ _____

Patient Signature *Date*

Renal Care Consultants, PC

Name: **Date of Birth:** **Date:**

Home Phone: **Cell:** **Work:**

Email Address: _____

Health Maintenance Information (please enter year done):

Bone Density Scan: _____
Colonoscopy: _____
Mammogram: _____
Pneumonia Vaccine: _____
Tetanus Vaccine: _____
Shingles Vaccine: _____

Primary Care Physician Name: _____ Phone: _____
Referring Physician Name: _____ Phone: _____
Cardiologist (if applicable): _____ Phone: _____
Endocrinologist (if applicable): Phone:

How would you like to receive reminders?(Check one) ☐ Mail ☐ Phone ☐ Web

The staff at Renal Care Consultants is trying to get a better sense of the overall diversity of our patient population and have a better understanding of our practice and patient needs. This confidential information is for quality monitoring purposes only and will not affect the quality of you receive at our office.

***** Please note: Primary Language is required. If you choose not to answer Race or Ethnicity, please check "unreported/Refuse to Report."***

Ethnicity:

☐ Hispanic or Latino
☐ Not Hispanic or Latino
☐ Unreported/Refused to Report

Primary Language Spoken: _____

Race:

☐ White
☐ Asian
☐ Pacific Islander
☐ Black/African American
☐ Native Hawaiian
☐ American Indian or Alaskan Native
☐ More than one race
☐ Unreported/Refused to Report

If you would like to give the staff of Renal Care Consultants, PC consent to disclose your health information to specific family members or friends, please list the names of those you would like us to have on file: (please include first and last name)

Spouse/Partner: _____ Phone _____
Caregiver: _____ Phone _____
Children: _____ Phone _____
Children: _____ Phone _____
Other: _____ Phone _____

By signing below, I authorize Renal Care Consultants to use and/or disclose my medical information to the person/persons listed above and aquire medication history from the nationwide database

_____ _____
Patient Signature *Date*