DALLAS RENAL GROUP PATIENT REGISTRATION

PATIENT INFORMATION: (Please use full legal name, no nickname) **DATE:** ____________________

Last Name: _________________________ First Name: ________________________ Middle Initial: _____

Address: ____

City: ___________________ State: _____ Zip code: _________ HOME Phone: ______-_____-______

CELL Phone: ______-_____-______ Social Security #: ___________________________________

Date of Birth: ______ Age: ____ Sex: ____ Marital Status: _____ Driver's License #: ________________

Race: ________________ Hispanic: Y or N Preferred Language: English Spanish Other: ___________

Primary Care Physician Name: ________________________ PCP office telephone #: ____-____-___________

Pharmacy Name: _____________________________ Phone: ___________________________________

Pharmacy Address: ____

Height: _________ Smoker: Y N Previous: Y N If current how much: ______ Pack per day

Emergency Contact Name: ________________________________ Emergency phone #: ____-_____-______

Employer Name: ____

Employer Address: ____

Work Phone #:______-______-________Occupation: ____

GUARANTOR INFORMATION: (If different from patient)

Last Name: ____________________________ First Name: ___________________________ Middle Initial: __

Date of Birth: ______________ Social Security #: _______________ Relationship: _____________

Employer Name: ________________________________ Phone #: _________________________

INSURANCE INFORMATION: (OR COPY OF INSURANCE CARD)

Primary: ____________________________ Address: ____

Phone #: ____________________________ ID #: ______________________ Group #: ________________

Subscriber: ____ Relationship: _________________________

Secondary: __________________________ Address: ____

Phone #:____________________________ ID #: ______________________ Group #: ________________

Subscriber: ____ Relationship: _________________________

COPAY $________________________________ **DEDUCTIBLE** $________________________________