

# 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 \$** \_\_\_\_\_