Southwest Kidney Care, LLC

Patient Information

Last Name:______________________________First Name:___________________________MI:______________

Address:____City:________________State:______Zip________

Home Phone:__________________________Cell:_______________________Work:_______________________

Email Address:____

Marital Status: Single Married Divorced Widowed Partner Legally Separated

Date of Birth:_____________Gender:_____________Social Security Number:___________________________

Race:___________________Ethnicity:___________Preferred Language:______________________________

Emergency Contact Name:______________________________Phone Number:_______________________

Relationship to Patient:____

Primary Care Physician:_________________________________Phone Number:_______________________

Preferred Pharmacy____

Insurance Information

Primary Insurance:____________________________________**Phone:**_________________________________

Subscriber's Name:____Date of Birth:______________________

Subscriber: Self Spouse Partner Other

Policy Number:____________________________ Group Number/Name:______________________________

Secondary Insurance:_________________________________**Phone:**________________________________

Secondary Subscriber's Name:______________________________Date of Birth:______________________

Subscriber: Self Spouse Partner Other

Policy Number:______________________________Group Number/Name:_____________________________

Responsible Party Information (if different from the patient)

Name:____Phone:___________________________

Address:____

City:____State:______________Zip:________________

Relationship to Patient:____

Southwest Kidney Care, LLC

Patient Informed Consent

- I voluntarily consent to any and all health care treatment and diagnostic procedures provided by Southwest Kidney Care, LLC and its associated physicians, clinicians, and other personnel. I am aware that the practice of medicine and other health care professions is not an exact science and I further state that I understand that no guarantee has been or can be made as to the results of the treatments or examinations at Southwest Kidney Care, LLC.

- I understand that Southwest Kidney Care, LLC will file all my insurance claims, provided I inform them of the correct policy information and that I have a current referral or prior authorization from my primary care provider as required by my insurance carrier
- I understand that I am financially responsible for all services provided.
- I authorize payment of medical benefits to Southwest Kidney Care, LLC or their designee for services rendered.
- I have received a copy of the Notice of Privacy Practices. **Initial: _______**

- I give permission to obtain all my medication/prescription history when using an electronic system to process prescriptions for my medical treatment. **Initial: _______**

Appointment Confirmation

I give Southwest Kidney Care, LLC permission to confirm my appointment and/or I authorize representatives of Southwest Kidney Care, LLC to leave appointment information on my home or mobile telephone numbers. **Initial: _______**

I give Southwest Kidney Care, LLC permission to send correspondence via email. **Initial: _______**

I give Southwest Kidney Care, LLC permission to send text messages to my mobile phone. **Initial: _______**

____

Patient or Authorized Representative Signature Date

____

Patient or Authorized Representative Name

Southwest Kidney Care

Patient Medication List

Patient Name:____**DOB:**________________________

Preferred Pharmacy Name/Address____

Phone: ___________________________

Are you allergic to any medications? **YES** **NO**

Please list:____

____

Please provide the names of all medications you are currently taking. This includes any over the counter medications or supplements. Include the Medication Name, Medication Dose/Strength (i.e. mg, mcg, mEq, etc.), and frequency of use (i.e. daily, twice daily, at bedtime, etc.)

If you are unsure about any of your medications, please bring all of your medication bottles in with you when you come to your appointment.

Medication	Dose/Strength	Frequency
1)________________________	__________	______________________
2)________________________	__________	______________________
3)________________________	__________	______________________
4)________________________	__________	______________________
5)________________________	__________	______________________
6)________________________	__________	______________________
7)________________________	__________	______________________
8)________________________	__________	______________________
9)________________________	__________	______________________
10)________________________	__________	______________________
11)________________________	__________	______________________

Patient Medication List

Medication	Dose/Strength	Frequency
12)________________________	__________	______________________
13)________________________	__________	______________________
14)________________________	__________	______________________
15)________________________	__________	______________________
16)________________________	__________	______________________
17)________________________	__________	______________________
18)________________________	__________	______________________
19)________________________	__________	______________________
20)________________________	__________	______________________
21)________________________	__________	______________________
22)________________________	__________	______________________
23)________________________	__________	______________________
24)________________________	__________	______________________
25)________________________	__________	______________________

Southwest Kidney Care

Patient History

Please complete the following sections to the best of your knowledge and as completely as possible. If none are applicable, please fill in with "N/A" or "Unknown".

Past Medical/Surgical History:

Family Medical History:

Social History: