Southwest Kidney Care, LLC

PATIENT DEMOGRAPHIC INFORMATION Date _____

Last Name_____ First Name _____M.I._____

SSN _____Birth Date_____

Patient Mailing Address_____

City_____ State _____ Zip Code _____

*Email Address _____ Primary Language _____

Home Phone _____ Day Phone _____

Cell Phone _____ OK to text appointment reminders to this number? Yes No

Emergency Contact Name: _____ Phone Number: _____

Marital Status: M S D W Primary Care Physician: _____

Preferred Lab:_____ Preferred Pharmacy: _____

Do you have a Power of Attorney? Y N If yes, Name _____Phone:_____

Do Not Resuscitate (DNR)☐ Full Code ☐ Do Not Intubate☐

Consent to virtual visits (doxy) ☐Yes ☐ No

Race: Asian African American Multi-racial Native American White Other Race Not Reported

Ethnicity: Hispanic or Latino Not Hispanic or Latino Unknown or Not Reported

Your e-mail address will not be disclosed to any other party, and you may opt out of future e-mail communications by notifying the receptionist.

INSURNACE INFORMATION:

Primary Insurance:_____ Secondary Insurance:_____

ID Number:_____ ID Number:_____

CONSENT TO TREAT	NOTICE OF PRIVACY PRACTICES
I hereby consent to treatment including tests, procedures and medications directed by **Southwest Kidney Care, LLC** providers.	I am aware of the facilities privacy practices.

PAYMENT OF BENEFITS / MEDICAL RELEASE AUTHORIZATION

I, the undersigned, authorize payment of benefits as determined by the Insurance Company, directly to Southwest Kidney Care, LLC. I authorize Southwest Kidney Care, LLC to release any information requested, including medical information, to any insurance company, employer, third party payer, third party administrator for purposes of processing my claims.

RESPONSIBLE PARTY STATEMENT

As the responsible party, I agree that I am responsible for payment of co-payments, co-insurance, and/or deductibles and noncovered services in accordance with the terms and conditions of my health insurance policy.

Responsible Party _____Relationship to Patient _____

(please print name)

Patient/Responsible Signature_____ Date _____