Patient Information

DOCTOR OF RECORD

Renal Specialists of Houston, PA

PATIENT NAME (First Name. Middle Initial, Last Name)	Home	SECOND PHONE (WORK)	THIRD PHONE (MOBILE)
ADDRESS	DATE OF BIRTH Age	SOCIAL SECURITY NUMBER	SEX (M or F)
CITY STATE, ZIP	MARITAL STATUS Married Single Other	EMERGENCY CONTACT PERSON	RELATIONSHIP TO PATIENT
ETHNICITY . Hispanic or Latino Non Hispanic or Latino Other . Caucasian Undetermined	RACE . Caucasian Asian Black or African American American Indian or Alaska Native . Latino Pacific Islander Multiracial		
EMPLOYER	OCCUPATION	CONTACT PHONE	PATIENT E-MAIL ADDRESS
REFERRING DOCTOR NAME & ADDRESS			
PRIMARY CARE DOCTOR NAME & ADDRESS			

Responsible Party

RESPONSIBLE PARTY NAME (First Name. Middle Initial. Last Name)
ADDRESS
CITY. STATE. ZIP
EMPLOYER

Primary Insurance

WHO IS THE PRIMARY INSURED PARTY (CHECK ONE)
. Patient (same as above) Responsible Party (same as above) Other (complete below)

INSURANCE COMPANY NAME COPAY AMOUNT	INSURED'S NAME (First Name, Middle Initial, Last Name)		
INSURANCE COMPANY ADDRESS	INSURED'S ADDRESS, CITY, STATE, ZIP		
INSURANCE COMPANY CITY, STATE. ZIP	INSURED'S DATE OF BIRTH	PRIMARY PHONE (HOME)	SECONDARY PHONE (WORK/CELL)
INSURANCE COMPANY PHONE NUMBERS	INSURED'S SOCIAL SECURITY NO.	INSURED'S SEX (M or F)	PATIENT'S RELATION TO INSURED
INSUREDS POLICY NUMBER INSURED'S GROUP #	INSURED'S EMPLOYER		INSURED'S OCCUPATION

Secondary Insurance

WHO IS THE SECONDARY INSURED PARTY (CHECK ONE)
. Patient (same as above) Responsible Party (same as above) Other (complete below)

INSURANCE COMPANY NAME	INSURED'S NAME (First Name, Middle Initial, Last Name)		
INSURANCE COMPANY ADDRESS	INSURED'S ADDRESS, CITY, STATE, ZIP		
INSURANCE COMPANY CITY, STATE. ZIP	INSURED'S DATE OF BIRTH		
INSURANCE COMPANY PHONE NUMBERS	INSURED'S SOCIAL SECURITY NO.	INSURED'S SEX (M or F)	PATIENT'S RELATION TO INSURED
INSUREDS POLICY NUMBER INSURED'S GROUP #	INSURED'S EMPLOYER		INSURED'S OCCUPATION

Authorization and Acknowledgement

I / We hereby state that the above information is true and correct to the best of my / our knowledge. I / We authorize the above named practice to release any information acquired in the course of my treatment to my insurance company, employer, Physicians, institutions or third party payors, as required for certain claims filed.

Signature of Patient / Parent / Guardian

Printed Name

Date

I / We authorize direct payment to be made to the above named practice for any and all medical or surgical services rendered. I understand if any services or charges are not covered by my insurance carrier or my eligibility can not be verified, I am responsible for all charges incurred.

Signature of Patient / Parent / Guardian / Insured

Printed Name

Date