

OKLAHOMA KIDNEY CARE

AMERICAN BOARD OF INTERNAL MEDICINE
NEPHROLOGY
DIALYSIS AND TRANSPLANTATION
HYPERTENSION

PATIENT INFORMATION (PLEASE PRINT)

Name: _____ Date: _____

Address: _____ City: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____ Sex: M F

Email Address: (for patient portal) _____

Date of Birth: _____ Age: _____ SSN: _____ Marital Status: S M W D SEP

Ethnicity: Hispanic or Latino Not Hispanic or Latino Unknown

Race: American Indian or Alaska Native Asian Black or African American
 Native Hawaiian or Other Pacific Islander White or Caucasian Other Race

Language: _____

Referred By: _____ Primary Care Physician: _____

Patient's Employer: _____ Position: _____

Business Address: _____

Spouse's Name: _____ Spouse's Employer: _____

PERSON RESPONSIBLE FOR BILL (IF OTHER THAN ABOVE)

Name: _____ Relationship: _____

Address (If other than above): _____ Phone: _____

Employer: _____ Position: _____

Business Address: _____ Phone: _____

INSURANCE INFORMATION

Name of Policy Holder: _____ SSN of Policy Holder: _____

Primary Insurance: _____ Group #: _____ Policy #: _____

Address: _____ Phone: _____

Secondary Insurance: _____ Group #: _____ Policy #: _____

Address: _____ Phone: _____

Tertiary Insurance: _____ Group #: _____ Policy #: _____

Address: _____ Phone: _____

NEAREST RELATIVE TO NOTIFY IN AN EMERGENCY

Name: _____ Relationship: _____

Address: _____ Phone: _____

Employer: _____ Position: _____ Phone: _____

Pharmacy: _____ Location: _____

Allergies: _____

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AUTHORIZATIONS

Financial Responsibility and Benefits to Physician:

I understand that I am financially responsible for services rendered by the physician and his/her staff, unless a contract exists between the physician and my insurance company that super cedes my financial obligation or in the case of authorized Worker's Compensation. I authorize my insurance company to pay benefits directly to the physician.

Date

Insured Signature

Release of Information:

I hereby authorize the release of any and all information from Oklahoma Kidney Care for insurance claim purposes. If some other party is paying the patient's bill or by any contract may be expected to pay the bill, then Oklahoma Kidney Care may disclose any or all of the patient's information to that party to verify charges. Oklahoma Kidney Care may disclose any or all of the patient's information to the patient's attending physician, consulting physician(s) and other health care provider who have a legitimate need for such information in the care and treatment of the patient. **The information released may include records which may indicate the presence of a communicable or venereal disease which may include, but are not limited to, diseases such as hepatitis, syphilis, gonorrhea and the human immunodeficiency virus, also known as acquired immune deficiency syndrome (AIDS).**

I understand all of the above and hereby state that the information is correct to the best of my knowledge. My signature indicates that I have read the above and grant the request of authorizations.

Date

Insured Signature

Acknowledgement of Receipt of Patient Privacy Notice:

I acknowledge I have been provided with a Patient Privacy Notice that provides a description of information uses and disclosures.

Date

Patient Signature