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: ____

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