Victoria Kidney & Dialysis Associates

REGISTRATION FORM

Name (First, Middle, Last) _____

Date of Birth _____ Sex ____M ____F Social Security Number_____

Address_____ City _____ State _____ Zip Code _____

Telephone _____ Work _____ Cell _____

Email Address: _____

Race: Caucasian African American Asian American Indian Other

Ethnicity: Hispanic: Mexican Other Non-Hispanic

Preferred Language _____

Primary Care Physician Office Number

Employment Status: Full Time Part Time Unemployed Retired Full Time Student

Employer Name_____

Marital Status: Married Single Separated Divorced Widowed

Spouse's Name _____ Date of Birth _____

Parent's Name _____

Emergency Contact Relationship Contact Number

Primary Insurance Carrier

Insurance Name _____ Member ID # _____ Group # _____

Insured's Name _____ Insured's SS# _____

Insured's Employer _____ Insured's Date of Birth _____

Patient's Relationship to Insured Self Spouse Dependent

Secondary Insurance Carrier

Insurance Name _____ Member ID # _____ Group # _____

Insured's Name _____ Insured's SS# _____

Insured's Employer _____ Insured's Date of Birth _____

Patient's Relationship to Insured Self Spouse Dependent

I authorize the release of any information necessary to process insurance claims and to obtain reimbursement. I request that payment of authorized benefits be made on my behalf to Victoria Kidney & Dialysis Associates. This assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for all deductible, co-pay, or balance not paid by my insurance.

Signature _____ Date _____