The Centers for Kidney Care

Patient Information Form

DATE _____

Patient's Name _____ Home Phone _____

Address 1 _____ Work Phone _____

Address 2 _____ Cell Phone _____

City _____ State _____ Sex: Male Female

Zip Code _____ County _____ Date of Birth _____

Social Security No. _____

Employer _____ Email Address _____

Employer's Address _____ **Marital Status** Single Married Divorced Widowed Separated

City _____ State ____ Zip _____

Employment Full time Part Time Not Employed Self-Employed Retired Military Duty

Primary Care Physician _____

PCP's Phone Number _____ **Student** Full Time Part Time Not a Student

Emergency Contact _____ Home Phone _____

Address _____ Work Phone _____

City _____ State ____ Zip _____ Cell Phone _____

Sex: Male Female Relationship _____ Date of Birth _____

Primary Insurance

Insurance Company _____

Policy Holder's Name _____

Relationship to Patient: Self Spouse Parent

Certification Number _____

Group Name _____ Group Number _____

Secondary Insurance

Insurance Company _____

Policy Holder's Name _____

Relationship to Patient: Self Spouse Parent

Certification Number _____

Group Name _____ Group Number _____

Race White Black/African American Asian Native Hawaiian or Other Pacific Islander American Indian/Alaska Native Decline to Specify

Ethnicity Hispanic/Latino Not Hispanic/Latino Unreported/Refused to Report

Language English Spanish Other _____