KIDNEY SPECIALISTS OF CENTRAL OKLAHOMA
PATIENT REGISTRATION

Name *(Last, First, M.I.):*	☐ M ☐ F	DOB:
Social Security Number:	Marital Status:	
Address:		
City, State, Zip:		
Home Phone:	Cell Phone:	Work Phone:
Email Address:		
Person Responsible for Account:		Phone:

Spouse's Name:	
Spouse's Employer:	Work Phone:
Emergency Contact:	Phone:
Relationship to Patient:	

Do you have an answering machine?	☐ Yes ☐ No	May we leave you a message pertaining to:	Medical Information?	☐ Yes ☐ No
May we contact you at work?	☐ Yes ☐ No		Appointment Reminders?	☐ Yes ☐ No
			Medications/Prescriptions?	☐ Yes ☐ No

Race:	☐ Decline to Answer ☐ White ☐ African American/Black ☐ Middle Eastern ☐ Asian
	☐ American Indian Tribe: ☐ Other:
Ethnicity:	☐ Decline to Answer ☐ Non-Hispanic or Non-Latino ☐ Hispanic or Latino
Primary Language:	☐ Decline to Answer ☐ English ☐ Spanish ☐ Vietnamese ☐ Chinese ☐ Other:

PRIMARY INSURANCE
Name of Insurance:
ID Number:
Group Number:
Name of Policy Holder:
Social Security Number:
Date of Birth:

SECONDARY INSURANCE
Name of Insurance:
ID Number:
Group Number:
Name of Policy Holder:
Social Security Number:
Date of Birth:

Federal law requires your permission before we discuss your healthcare with any friends or family members.
Please list any persons (besides your other physicians) with whom we may discuss your care:

Name	Relationship to Patient:

I authorize my insurance company to pay benefits directly to Kidney Specialists of Central Oklahoma and/or its physicians. I understand that I am financially responsible for services rendered by the physician and his/her staff as determined by my insurance company. I also understand that all copays are due at the time of my visit. I agree that all the above information is true and correct to the best of my knowledge. In accordance with HIPAA regulations, I acknowledge that I have been given a copy of Kidney Specialists' Notice of Health Information Practices.

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Signature of Patient or Legal Representative Date