Patient Information
(Please Print)

Chose clinic because/Referred to clinic by **(please check one box):**

❑ Dr._____ ❑ Insurance Plan ❑ Hospital ❑ Family ❑ Friend ❑ Yellow Pages ❑ Other

Primary Care Physician: _____

Name: _____
(Last) (First) MI

DOB: _____ Age: _____ SS# _____SEX: ❑ M ❑ F Status: ❑ S ❑ M ❑ D ❑W
Address:

_____
(Street)

_____
(City) (State) (Zip)

Home Phone:(_____)-_____ Cell Phone (_____)-_____

Employment
Employer: _____ Work Phone:(_____)-_____
Address:

_____
(Street)

_____
(City) (State) (Zip)

Emergency Contact

_____ (_____) _____
(Name) (Phone) (Relationship)

Insurance
Primary Insurance Company:_____

Insurance Address:_____

Policy #_____ Group #_____

Cardholder:_____ Insurance Phone :_____

Secondary Insurance Company:_____

Insurance Address:_____

Policy #_____ Group #_____

Cardholder: _____ Insurance Phone: _____
I herby consent to treatment by the physicians and/or associates of North Texas Kidney Consultants.

Signature: _____Date:_____
I herby assign my insurance benefits to be paid directly to North Texas Kidney Consultants.
I understand that I am financially responsible for all charges not covered by this assignment.

Signature: _____Date_____