DIALYSIS ACCESS CENTER PATIENT REGISTRATION FORM

PATIENT INFORMATION:

Last Name: _____ First Name _____MI_____

Date of Birth: _____Age: _____Sex: Male ☐ Female ☐

Social Security # _____ Marital Status: _____

Home Address: _____

City, State and Zip Code: _____

Home Phone # _____Cell #_____

EMPLOYMENT INFORMATION:

Employer:_____

Employer Address: _____

Employer Phone #: _____ If Retired, Date of Retirement _____

EMERGENCY CONTACT INFORMATION:

_____

Contact Name Relationship to Patient Phone Number

INSURANCE INFORMATION:

Primary Insurance: _____

Address/Phone #:_____

Subscriber Name: _____
ID #: _____ Group #: _____
Effective Date: _____ Auth #: _____

Secondary Insurance: _____

Address/Phone #:_____

Subscriber Name: _____
ID #: _____ Group #: _____
Effective Date: _____ Auth #: _____

MSP INFORMATION

Date of 1st Visit: _____ Date of 1st Dialysis: _____ Date of Transplant: _____
Are you entitled to Medicare because of a disability other than End Stage Renal Disease? _____ Yes _____No
If yes, date disability began: _____
Is this illness or injury the result of an automobile accident, work related, or other injury? _____Yes _____No
If yes, please explain: _____