RNA
Rockford Nephrology Associates

PATIENT REGISTRATION FORM

Patient Name: _____ _____ _____ Date of Birth: ____/____/____
(Last Name and Suffix - i.e. Sr, Jr) (First Name) (M.I.)

Social Security # ___-___-____ Gender: Male ____ Female ____ Marital Status: S M D W Other____

Ethnicity: ☐ African-American ☐ Alaska Native ☐ Asian ☐ American Indian ☐ Hispanic / Latino
☐ Native Hawaiian ☐ White/Caucasian ☐ Other Pacific Islander ☐ Other: _____

Physical Address: _____

City: _____ State: _____ Zip: _____

Billing Address: ☐ Same as above -or- _____
If home address and billing address differ, please write billing address on the line provided.

Home Phone: (____) _____ Work: (____) _____ Cell: (____) _____

Email Address: _____ Primary Care Provider: _____

Spouse's Name: _____ Preferred Hospital: _____

Spouse's Date of Birth: ____/____/____ Preferred Laboratory: _____

Preferred Pharmacy: _____ Pharmacy History Consent: Yes _____ No _____

Employment Status

☐ Working Full-Time Employer Name/Occupation: _____

☐ Working Part-Time Employer Name/Occupation: _____

☐ Retired Date _____ Employer Name/Occupation: _____

☐ Unemployed, Currently not working -or- ☐ Disabled, as of _____(date)

Insurance / Guarantor Information

Do you have health insurance? Yes ☐ No ☐ Insurance Name: _____

Is the patient the policyholder? Yes ☐ No ☐ – the policy belongs to my Spouse ☐ Parent ☐ (Other) ☐

If the Guarantor (individual responsible for payment) is NOT the patient, please complete the following:

Guarantor Name: _____ Date of Birth: ____/____/____

SSN: ___-___-____ Gender: Male _____ Female _____ Relationship to Patient: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: (____) _____ Work: (____) _____ Cell: (____) _____

Do you have secondary insurance? Yes☐ No ☐ Insurance Name: _____

Emergency Contacts

Emergency Contact 1: _____ Relationship: _____ Phone: (____) _____

Emergency Contact 2: _____ Relationship: _____ Phone: (____) _____