Connecticut KIDNEY Center

Registration Information

Name: _____

Address: _____

City: _____ **State:**_____ **Zip:**_____

Employment Status: Full / Part / Retired / Disabled / Student / Self / Unemployed

Employer Name: _____

Employer Address: _____

_____

Employer Phone: **(____) _____ - _____**

Referring Physician: _____

Primary Care Physician :_____

Pharmacy Name and Phone:

_____

DOB: _____ / _____ / _____

Gender: Male / Female

SS# _____-_____-_____

Tele: H (_____)_____ - _____

W (_____)_____ - _____

C (_____)_____ - _____

Preferred number for office messages: Home / Work / Cell

Marital Status: Single/ Married / Divorced / Widow / Other

Preferred Language:_____

Ethnicity: Hispanic or Latino / Not Hispanic or Latino

Race: Black or African American / White / Asian / American Indian or Alaska Native/ Native Hawaiian or Other Pacific Islander / Other

Emergency Contact (*Person not living with you)*

Person to notify in event of an emergency: _____ **Relationship:** _____

Phone: Day (_____) _____ - _____ Eve: (____) _____ - _____ Alt: (____) _____ -_____

Insurance Information

Primary Insurance:

Referral Required? ☐ Yes ☐ No

Insurance Plan: _____ ID#: _____ Group#: _____

Subscriber Name: _____ DOB: _____ / _____ / _____ Employer: _____

Secondary Insurance:

Referral Required? ☐ Yes ☐ No

Insurance Plan: _____ ID#: _____ Group#: _____

Subscriber Name: _____ DOB: _____ / _____ / _____ Employer: _____

Agreement/Authorized Signature for Medical Information: *I authorize release of medical information necessary to process my claims and I direct payment of my insurance benefit to Connecticut Kidney Center, L.L.C.. I also understand if any information such as referral forms, insurance forms, prior authorization or certification, etc., is needed prior to my visit, I will provide Connecticut Kidney Center, L.L.C. with said information. If said information is not provided, I understand I will be held responsible for payment in full at time of service or my account will be turned over to a collection agency.* **Agreement/Authorized Signature for Medicare Patients Only**: *I request that payment of authorized Medicare benefits be made to Connecticut Kidney Center, L.L.C. for any covered services furnished to me by this group. I authorize any holder of medical information about me release to the Health Care Financing Administration and its agents, any information needed to determine benefits payable for related services.*

Patient Signature: _____ **Date:** _____ / _____ / _____

Connecticut KIDNEY Center

Patient History Form

Name: _____ **DOB:** ____ / ____ / ____ **Phone:** (____) ____ - _____

Reason for Visit: _____

Previous Surgeries:

Date:	Hospital:	Procedure:	Surgeon:
____ / ____ / ____	_____	_____	_____
____ / ____ / ____	_____	_____	_____
____ / ____ / ____	_____	_____	_____
____ / ____ / ____	_____	_____	_____
____ / ____ / ____	_____	_____	_____
____ / ____ / ____	_____	_____	_____
____ / ____ / ____	_____	_____	_____

Previous Hospitalizations:

Date:	Hospital:	Reason:
____ / ____ / ____	_____	_____
____ / ____ / ____	_____	_____
____ / ____ / ____	_____	_____
____ / ____ / ____	_____	_____
____ / ____ / ____	_____	_____
____ / ____ / ____	_____	_____

Please check if you have or have had in the past, any of the following conditions:

- ☐ Diabetes
- ☐ Emphysema
- ☐ Thyroid Disease
- ☐ High Blood Pressure
- ☐ Kidney Disease or Kidney Stones
- ☐ Bowel Disease
- ☐ Asthma
- ☐ Heart Disease
- ☐ Skin Conditions
- ☐ Tuberculosis
- ☐ Arthritis
- ☐ Ulcers

Other: _____

_____

Current Medications: *(please use attached form)*

Medication Allergies: _____

Medication List

Date: ____ / ____ / ____

Patient Name: _____ DOB: ____ / ____ / ____

Pharmacy Name: _____ Location: _____

Medication:	Dosage:	Instructions:	Prescribing MD:

ACKNOWLEDGMENT OF OUR NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received or have been given the opportunity to receive a copy of Connecticut Kidney Center's Notice of Privacy Practices. By signing below I am ***only*** giving acknowledgment that I have received or have had the opportunity to receive the Notice of our Privacy Practices.

_____ _____

Patient Name (Print) Date

_____

Patient Signature / (Personal Representative)

___ Patient would not accept the Notice of Privacy Practices

___ Patient was given the Notice of Privacy Practices but declined to sign the acknowledgement

Employees Initials _____