

CENTRAL ALABAMA KIDNEY AND HYPERTENSION CENTER, PC

NAME _____

PRIMARY INSURANCE _____

DOB _____ **GENDER** M ___ F ___

Contract number _____

SSN _____ **RACE** _____

Subscriber _____

MARITAL STATUS _____ **Language** _____

Relationship to Policy Holder _____

ADDRESS _____

Complete if patient is not the policy holder:

CITY _____

Policy Holder _____

ST _____ **ZIP** _____

SSN _____ **DOB** _____

Home Ph # _____

Employer _____

Cell Ph # _____

SECONDARY INSURANCE _____

Work Ph # _____

Contract Number _____

Email _____

Subscriber _____

EMPLOYER _____

Employer _____

Employer Address _____

SSN _____ **DOB** _____

Employer Phone _____

ADDITIONAL POLICY _____

EMERGENCY CONTACTS

Contract Number _____

Contact #1 _____

Relationship to Policy Holder _____

Relationship _____

Complete if patient is not Policy Holder:

Home Ph _____

Policy Holder _____

Cell _____ Work _____

SSN _____ **DOB** _____

Contact #2 _____

Pharmacy Information

Relationship _____

Pharmacy _____

Home Ph _____

Phone # _____

Cell _____ Work _____

PRIMARY CARE PROVIDER _____

Preference for reminders: Mail _____ Phone _____ e-mail _____