Mountain Kidney & Hypertension Associates

Last Name:_____ First Name: _____

Address: _____

City: _____State:_____Zip:_____

Home Phone:_____/_____/_____ Cell Phone:_____/_____/_____

Work Phone:_____/_____/_____ Email Address: _____

DOB: _____/_____/_____ SSN: _____/_____/_____ Sex: M F Race: _____

Marital Status:(circle) Married Divorced Single Separated Widowed

Primary Care Physician / phone number: _____

Primary pharmacy / phone number: _____

Employer: _____

Employer Address: _____

Employer City: _____State:_____Zip:_____Phone: _____/_____/_____

Emergency Contact: _____

Emergency Contact Phone: _____

Primary Insurance Name: _____

Address: _____ City: _____State:____ Zip:_____

Policy ID#_____Policy Holder: _____DOB: ___/____/____

Secondary Insurance Name: _____

Address: _____ City: _____State:____ Zip:_____

Policy ID#_____Policy Holder: _____DOB: ___/____/____

Tertiary Insurance Name: _____

Address: _____ City: _____State:____ Zip:_____

Policy ID#_____Policy Holder: _____DOB: ___/____/____

I hereby authorize the release of any medical records necessary to process my Medicare, Medicaid and/or insurance claims and for any benefits payable under my policy to be paid directly to Mountain Kidney & Hypertension Assoc., PA. I understand that I am responsible for payment of any amount <u>not</u> covered by my insurance.

Patient/Responsible Party Signature: _____ Date: _____ (Rev 1/15)