REGISTRATION FORM

(Please print or download the PDF Form to type in information)

KIDNEY CARE INSTITUTE

Today's date: _____ PCP: _____

PATIENT INFORMATION

Patient's last name: _____First: _____ Middle: _____

Suffix: ☐ Mr. ☐ Mrs. ☐ Miss. ☐ Ms. Marital Status: ☐ Si ☐ M ☐ D ☐ Sep ☐ W

Is this your legal name? ☐ Y ☐ N If not, what is your legal name? (Former name): _____

Birth date: _____ Age: _____ Sex: _____

Street address: _____ P.O. box: _____

City: _____ State: _____ ZIP Code: _____

Home phone #: _____ Cell Phone: _____Work: _____

Occupation: _____

Choose clinic because/Referred to clinic by (please check one box): ☐ Dr. ☐ Insurance Plan ☐ Hospital

☐ Family ☐ Friend ☐ Close to home/work ☐ Yellow Pages ☐ Other

Other family members seen here: _____

INSURANCE INFORMATION (Please give your insurance card to the receptionist.)

Person responsible for bill: _____ Birth date:_____

Street address: _____ P.O. box: _____

City: _____ State: _____ ZIP Code: _____

Home phone #: _____ Cell Phone: _____Work: _____

Is this person a patient here? ☐ Yes ☐ No

Is this patient covered by insurance? ☐ Yes ☐ No

Please indicate primary insurance ☐ Medicare ☐ Medical ☐ Medi-Medi ☐ Health Net ☐ Anthem ☐ BlueCross

☐ Cigna PPO ☐ Blue Cross/Blue ☐ Shield PPO ☐ HMO ☐ Other

Subscriber's name: _____ Subscriber's S.S. #:_____

Birth date: _____ Group #:_____Policy #: _____ Co-payment: _____

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

Name of secondary insurance (if applicable):_____

Subscriber's name: _____ Subscriber's S.S. #:_____

Birth date: _____ Group #:_____Policy #: _____ Co-payment: _____

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

IN CASE OF EMERGENCY

Emergency contact (not living at same address): _____ Relationship: _____

Home phone #: _____ Cell Phone: _____Work: _____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Kidney Care Institute, Inc. or insurance company to release any information required to process my claims.

Patient/Guardian _____

Signature_____ Date _____

CONSENT FORM

(Please print or download the PDF Form to type in information)

KIDNEY CARE INSTITUTE

I _____ authorize Vincent L. Anthony MD., to provide those diagnostic preventive and therapeutic services which are deemed necessary for my health care.

Patient, Parent, or Legal Guardian Signature_____ Date _____

CONSENT TO TREATMENT OF A MINOR

If the patient is a minor, or in any way incapacitated to sign for him/her self, this form is to be completed for each minor and filed in minor's chart.

To: Kidney Care Institute, its doctor, nurses, and members of staff

Re: _____, a minor Date of Birth _____

ID number_____

(I), (We), the undersigned parent(s) or legal guardian(s) of minor, _____ authorized Kidney Care Institute, to whom the minor has been entrusted to act on my (our) behalf to consent to x-ray examination, anesthetic, medical o surgical diagnosis or treatment and care which is deemed advisable by, and is to be rendered under general and special supervision of any duly licensed physician. Additionally, in accordance with California Health and Safety Code, section 1283, (I), (We), authorized KIDNEY CARE INSTITUTE or parties rendering care on its behalf to release the minor to the physical custody of _____ upon completion of the diagnosis treatment of care.

This authorization shall remain in effect _____, unless sooner revoke in writing and delivered to KIDNEY CARE INSTITUTE.

Parent or Legal Guardian _____ Date _____