TEXAS NEPHROLOGY & HYPERTENSION SPECIALISTS

Texas Nephrology and Hypertension Specialists, P.A.
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DOCTOR OF RECORD

## Patient Information

**Renal Specialists of Houston, PA**

| | | | |
|---|---|---|---|
| PATIENT NAME (First Name. Middle Initial, Last Name) | Home | SECOND PHONE (WORK) | THIRD PHONE (MOBILE) |
| ADDRESS | DATE OF BIRTH Age | SOCIAL SECURITY NUMBER | SEX (M or F) |
| CITY STATE, ZIP | MARITAL STATUS<br>Married Single Other | EMERGENCY CONTACT PERSON | RELATIONSHIP TO PATIENT |
| ETHNICITY<br>. Hispanic or Latino Non Hispanic or Latino Other<br>. Caucasian Undetermined | RACE<br>. Caucasian Asian Black or African American American Indian or Alaska Native<br>. Latino Pacific Islander Multiracial | | |
| EMPLOYER | OCCUPATION | CONTACT PHONE | PATIENT E-MAIL ADDRESS |
| REFERRING DOCTOR NAME & ADDRESS | | | |
| PRIMARY CARE DOCTOR NAME & ADDRESS | | | |

## Responsible Party

| |
|---|
| RESPONSIBLE PARTY NAME (First Name. Middle Initial. Last Name) |
| ADDRESS |
| CITY. STATE. ZIP |
| EMPLOYER |

## Primary Insurance

WHO IS THE PRIMARY INSURED PARTY (CHECK ONE)
. Patient (same as above) Responsible Party (same as above) Other (complete below)

| | | | |
|---|---|---|---|
| INSURANCE COMPANY NAME COPAY AMOUNT | INSURED'S NAME (First Name, Middle Initial, Last Name) | | |
| INSURANCE COMPANY ADDRESS | INSURED'S ADDRESS, CITY, STATE, ZIP | | |
| INSURANCE COMPANY CITY, STATE. ZIP | INSURED'S DATE OF BIRTH | PRIMARY PHONE (HOME) | SECONDARY PHONE (WORK/CELL) |
| INSURANCE COMPANY PHONE NUMBERS | INSURED'S SOCIAL SECURITY NO. | INSURED'S SEX (M or F) | PATIENT'S RELATION TO INSURED |
| INSUREDS POLICY NUMBER INSURED'S GROUP # | INSURED'S EMPLOYER | | INSURED'S OCCUPATION |

## Secondary Insurance

WHO IS THE SECONDARY INSURED PARTY (CHECK ONE)
. Patient (same as above) Responsible Party (same as above) Other (complete below)

| | | | |
|---|---|---|---|
| INSURANCE COMPANY NAME | INSURED'S NAME (First Name, Middle Initial, Last Name) | | |
| INSURANCE COMPANY ADDRESS | INSURED'S ADDRESS, CITY, STATE, ZIP | | |
| INSURANCE COMPANY CITY, STATE. ZIP | INSURED'S DATE OF BIRTH | | |
| INSURANCE COMPANY PHONE NUMBERS | INSURED'S SOCIAL SECURITY NO. | INSURED'S SEX (M or F) | PATIENT'S RELATION TO INSURED |
| INSUREDS POLICY NUMBER INSURED'S GROUP # | INSURED'S EMPLOYER | | INSURED'S OCCUPATION |

## Authorization and Acknowledgement

I / We hereby state that the above information is true and correct to the best of my / our knowledge. I / We authorize the above named practice to release any information acquired in the course of my treatment to my insurance company, employer, Physicians, institutions or third party payors, as required for certain claims filed.

Signature of Patient / Parent / Guardian _____ Printed Name _____

Date _____

I / We authorize direct payment to be made to the above named practice for any and all medical or surgical services rendered. I understand if any services or charges are not covered by my insurance carrier or my eligibility can not be verified, I am responsible for all charges incurred.

Signature of Patient / Parent / Guardian / Insured _____ Printed Name _____

Date _____