KIDNEY SPECIALISTS OF NORTH HOUSTON

REGISTRATION FORM

(Please Print)

PCP:				Today's Date:		
Other doctors you see:						
PATIENT INFORMATION						
Patient's last name: First: Middle:			❑ Mr. ❑ Mrs. ❑ Dr.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Widow	
Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F	
Race (please circle): American Indian Asian African American Black White Hispanic Other						
Street address:		Social Security no.:				
P.O. box:	City:		State:	ZIP Code:		
Occupation:	Employer:		Employer phone no.: ( )			
How did you hear about Kidney Specialists of North Houston?	❑ Dr.	❑ Insurance Plan	❑ Hospital			
❑ Family	❑ Friend	❑ Close to home/work	❑ Yellow Pages	❑ Website	❑ Other	
Phone numbers (please circle preferred contact number)	Cell:	Home:	Work:			
May we leave a voicemail on the preferred number?	Yes No	E-Mail Address				

PHARMACY INFORMATION	
Pharmacy Name:	Phone number: ( )
Address:	

INSURANCE INFORMATION			
(Please present a current insurance card to the medical assistant)			
Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )
Is this person a patient here? ❑ Yes ❑ No			
Occupation:	Employer:	Employer address:	Employer phone no.: ( )
Is this patient covered by insurance? ❑ Yes ❑ No			
Please indicate primary insurance			
Patient's relationship to subscriber:	❑ Self ❑ Spouse ❑ Child ❑ Other		
Name of secondary insurance (if applicable):	Subscriber's name:		

129 Vision Park Drive Suite 109 ▪ The Woodlands, TX 77384 ▪ Office: 936-273-0836 ▪ Fax: 936-321-2266
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Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.:	Work phone no.:
		( )	( )
Is there anyone else you would like to have access to your personal health information?	YES	NO	
Name:			

MEDICAL HISTORY

Reason for visit today:

Allergies:

Past Medical History:	Past Surgical History:

MEDICATIONS

Please list all current medications, dose, and frequency.
Please include over the counter and any herbal medications.

SOCIAL HISTORY

Do you smoke?	How much and how long?
Do you drink alcohol?	How much and how often?

FAMILY HISTORY

Any family history of the following?

Kidney failure High blood pressure Diabetes Cancer Stroke Heart attack

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