Renal Care Consultants, P.C.

760 Golf View Drive, Suite 200, Medford, OR 97504
Phone: (541) 618-4400 Fax: (541) 618-4406

Patient Name_____ Date of Birth_____ Gender: Male / Female

Social Security #_____ Marital Status: Single Married Separated Divorced Widowed

Mailing Address_____ City_____ State_____ Zip_____

Street Address (if different)_____

Home Phone_____ Cell_____ Email_____

Employer_____ Work Phone_____

RACE – Please select one or more of the following:

White Latino/Hispanic American Indian/Alaska Native Asian Black-African/American

Native Hawaiian Pacific Islander Other_____

Preferred Language:_____

PRIMARY INSURANCE

Insurance Company_____ ID#_____ Group#_____

Subscribers Name_____ Subscribers Date of Birth_____

Address (if different from patient)_____ Phone_____

Relationship to Patient_____ Employer_____ Work Phone_____

SECONDARY INSURANCE

Insurance Company_____ ID#_____ Group#_____

Subscribers Name_____ Subscribers Date of Birth_____

Address (if different from patient)_____ Phone_____

Relationship to Patient_____ Employer_____ Work Phone_____

PATIENT/AUTHORIZED PERSON'S SIGNATURE: I authorize treatment of the patient listed above. I hereby authorize Renal Care Consultants P.C. to release any information as may be required by an attorney, insurance company or referring physicians for the purpose of medical treatment or follow up. I hereby assign all payments directly to Renal Care Consultants P.C. to which I am entitled for expenses related to services performed. I understand I am financially responsible for all charges. Should it become necessary to collect monies in court, all court costs and attorney fees are my responsibility. I attest that the above information is true and correct to the best of my knowledge.

_____ _____ _____

Responsible Party Signature Relationship to Patient Date