RENALCARE Consultants, P.C.

KIDNEY DISEASE • HYPERTENSION • ADULT MEDICINE • TRANSPLANTATION • DIALYSIS

Patient Name _____ Date of Birth _____

First, Middle, Last

Emergency Contact _____ Relationship _____

Primary Phone _____ Secondary Phone _____

Do we have your permission to discuss your health information with this person? **YES** **NO**

Primary Care Doctor _____ Phone _____

Referring Doctor _____ Phone _____

Other Specialists Providing Care

Name _____ Phone _____

Name _____ Phone _____

Name _____ Phone _____

If you have an answering machine or voicemail, may we leave a message? Yes No

If you would like to give the staff of Renal Care Consultants PC consent to disclose your health information to specific family members or friends, please list the names of those you would like us to have on file:

Please include first and last name

Name _____ Phone _____ Relationship _____

Name _____ Phone _____ Relationship _____

Name _____ Phone _____ Relationship _____

Name _____ Phone _____ Relationship _____

Name _____ Phone _____ Relationship _____

Name _____ Phone _____ Relationship _____

Health Maintenance Information

	MONTH	YEAR		MONTH	YEAR
Bone Density Scan:			Colonoscopy:		
Mammogram:			Pneumonia Vaccine:		
Tetanus Vaccine:			Shingles Vaccines:		
Flu Vaccine:			Covid Vaccine		

PATIENT OR AUTHORIZED PERSON'S SIGNATURE: By signing below, I authorize Renal Care Consultants to use and/or disclose my medical information to the person/persons listed above and acquire medication history from the nationwide database.

Patient/Guardian Signature **Relationship to Patient** **Date**