TEXAS KIDNEY PARTNERS

2001 Auburn Hills Pkwy, Ste 801, McKinney, TX 7507

Patient Information

Last name: _____ **First name:** _____ **Middle initial:** _____

If minor, name of responsible parent: _____

Name you would like to appear on your health records: _____

What are your pronouns: ☐He/him ☐She/her ☐They/them ☐Other: _____

DOB: _____ **Social Security#:** _____ **Drivers license #:** _____

Home address*: _____ **APT/suite #:** _____

City: _____ **State:** _____ **ZIP:** _____

Pick one: **Home #:** ☐ _____ **Mobile #:** ☐ _____ (Checkmark the best number to use)

Email address*: _____

Do you think of yourself as:

☐ Male ☐ Female ☐ Transgender man/trans man ☐ Transgender woman/trans woman

☐ Genderqueer/gender nonconforming, neither exclusively male nor female

☐ A category not listed here, please specify: _____ ☐ Decline to answer

Do you think of yourself as:

☐ Straight or heterosexual ☐ Lesbian or gay ☐ Bisexual ☐ Queer, pansexual and/or questioning

☐An orientation not listed here, please specify: _____ ☐ Don't know ☐ Decline to answer

Occupation: _____

Employer: _____

Phone #: _____

Address: _____ **City:** _____ **State:** _____ **ZIP:** _____

EDUCATION, LANGUAGE & DEMOGRAPHICS

Highest level of education: _____

Preferred language: _____ **Do you need an interpreter?:** _____

Ethnicity: _____ **Race:** _____

IF APPLICABLE, NAME OF SPOUSE/DOMESTIC PARTNER

Last name: _____ **First name:** _____ **Middle initial:** _____

IF THE PATIENT IS LIVING IN A NURSING OR ASSISTED LIVING FACILITY

Name of facility: _____

Address: _____ **Room #:** _____

City: _____ **State:** _____ **ZIP:** _____

CONTACT INFORMATION FOR RESPONSIBLE PARTY/SPOUSE/PARENT (If info same as above, leave blank)

Last name: _____ **First name:** _____ **Middle initial:** _____

Social security #: _____ **Relationship to patient:** _____

Address: _____ **City:** _____ **State:** _____ **ZIP:** _____

Home #: _____ **Cell #:** _____ **Email address:** _____

PATIENT REFERRAL INFORMATION			
Patient referred by			Phone #
Address	City	State	ZIP
Primary care physician*			Phone #
Address	City	State	ZIP

EMERGENCY CONTACTS (PLEASE PROVIDE TWO WITH DIFFERENT CONTACT INFORMATION)			
Name	Relationship		Phone #
Address	City	State	ZIP
Name	Relationship		Phone #
Address	City	State	ZIP

Who can we share your information with?

Patient signature: _____ **Date:** _____

Patient representative/parent: _____ **Date:** _____

For patients requiring translation or verbal reading of the document, the reader or translator may document and sign below.

Reader/translator: _____ **Date:** _____

Billing Information & Responsible Party/Insurance Information

Last name: _____ **First name:** _____ **Middle initial:** _____

INSURANCE INFORMATION	
Primary insurer	Name of insured
Insurance ID# / Group # / Other information	
Secondary insurer	Name of insured
Insurance ID# / Group # / Other information	
Tertiary insurer	Name of insured
Insurance ID# / Group # / Other information	
Pharmacy insurer	Name of insured
Insurance ID# / BIN # / PCN # / Group # / Other information	

Patient signature: _____ **Date:** _____

For office use only:

Physician to be seen _____ **Date:** _____

Account number assigned: _____ **Initials:** _____