Northwest Renal Clinic Patient Registration Form

Patient Name:

(Last)_____ (First) _____ (MI) _____

Date of Birth: _____ **Social Security Number:** _____

Sex: Male /Female

Mailing Address: _____

City: _____ **State:** _____ **Zip:** _____

Primary Phone: _____ **Secondary Phone:** _____

Email Address: _____ @ _____

Emergency Contact: (Name) _____

Phone: _____ **Relationship:** _____

Preferred Language: _____

Race (These are the options in our computer) please circle one:

	African American	American Indian or Alaska Native	
Caucasian	Chinese	Filipino	Japanese
Multi Racial	Pacific Islander	Native Hawaiian	Other

Ethnicity: Hispanic or Latino Non-Hispanic or Latino Other or Undetermined

Current Marital Status: Single Married Divorced Widowed Separated

Primary Care Physician Name: _____ **Phone:** _____

Referring Physician Name: _____ **Phone:** _____

Preferred Pharmacy: _____

Address: (approximate) _____ **Phone:** _____

Patient Signature: _____ **Date:** _____

Office Use Only:

Updated:

Centricity ☐ Ideal ☐ Orchard ☐

Staff _____ Date _____