Patient Registration Form

Name:_____ Date of Birth:_____ SSN:_____

Address:_____

Phone Number: (H)_____ (C)_____ Email:_____

Emergency Contact Name:_____ Number:_____ Relationship:_____

Marital Status: □Single □Married □Divorced □Widowed

Language: □English □Non-English speaking

Race: □African American □Asian □Caucasian □Hispanic □Native American

Ethnicity: □Hispanic or Latino □Non-Hispanic or Latino

Sex: □Male □Female

Code Status: □Full Code □DNR □DNI □DNR/DNI

Primary Care Doctor:

Name:_____Address:_____

_____Phone number: _____

Referring Provider:

Name: _____ Address:_____

_____ Phone Number:_____

Other Care Team: (where we will send correspondence about your care to)

Name: _____ Address: _____

_____ Phone Number: _____

Name: _____ Address: _____

_____ Phone Number: _____

Name: _____ Address: _____

_____ Phone Number: _____

Dialysis Patients:

Nephrologist: _____ Dialysis Unit: _____Days: _____

Are you Diabetic: □No □Yes If yes, do you have a Podiatrist: □No □Yes

Name of Podiatrist: _____