HUNTSVILLE RENAL CLINIC

Patient Demographic & Registration Form

810 Franklin Street Suite A
Huntsville, AL 35801
Phone: 256-533-7676 Fax: 256-533-3171
huntsvillerenalclinicpc.com

Please complete all sections in black or blue ink. All information is kept strictly confidential per HIPAA regulations. Fields marked with * are required.

1 PATIENT INFORMATION

Last Name * | First Name * | Middle Initial | Suffix (Jr./Sr./III)

Preferred Name / Nickname | Date of Birth * (MM/DD/YYYY) | Age | Sex Assigned at Birth *

☐ Male ☐ Female ☐ Intersex ☐ Unknown / Decline to State

Social Security Number * (XXX-XX-XXXX) | Marital Status | Preferred Language | Interpreter Needed?

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Other

☐ Yes ☐ No

Race / Ethnicity | Religion (optional)

Employer / Occupation | Employer Phone Number

2 CONTACT INFORMATION

Home / Mailing Address * | Unit / Apt #

City * | State * | ZIP Code * | County

Home Phone | Cell Phone * | Work Phone

Email Address

Preferred Contact Method

☐ Home Phone ☐ Cell Phone ☐ Work Phone
☐ Email ☐ Text Message ☐ All of the Above

May we leave a voicemail? * ☐ Yes ☐ No

May we leave a message? ☐ Yes ☐ No

3 EMERGENCY CONTACT

Emergency Contact Name * | Relationship to Patient *

Primary Phone * | Secondary Phone | Email Address

Second Emergency Contact (optional)

Name | Relationship to Patient

Primary Phone | Secondary Phone | Email Address

4 PRIMARY CARE & REFERRING PHYSICIAN

Primary Care Physician (PCP) Name | PCP Practice / Clinic

PCP Phone Number | PCP Fax Number | PCP City / State

Referring Physician (if different from PCP)

Referring Physician Name | Referring Practice / Clinic

Referring Physician Phone | Referring Physician Fax | Reason for Referral

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5 PRIMARY INSURANCE

Insurance Company Name * | Plan / Group Name

Member / Policy ID Number * | Group Number | Insurance Phone

Policy Holder Name * | Policy Holder DOB | Relationship to Patient

☐ Self ☐ Spouse ☐ Child ☐ Parent ☐ Other

Policy Holder Employer | Policy Holder SSN (if required)

Effective Date | Termination Date (if known) | Co-pay Amount | Deductible Amount | Out-of-Pocket Max

6 SECONDARY INSURANCE (if applicable)

Insurance Company Name | Plan / Group Name

Member / Policy ID Number | Group Number | Insurance Phone

Policy Holder Name | Policy Holder DOB | Relationship to Patient

☐ Self ☐ Spouse ☐ Child ☐ Parent ☐ Other

Effective Date | Termination Date (if known) | Co-pay Amount | Deductible Amount | Out-of-Pocket Max

7 PHARMACY INFORMATION

Preferred Pharmacy Name | Pharmacy Phone

Pharmacy Address | City / State / ZIP

8 AUTHORIZATION, CONSENT & SIGNATURE

Release of Information: I authorize Huntsville Renal Clinic to release medical records to insurers, referring physicians, and other providers as necessary for treatment and billing.

Assignment of Benefits: I authorize direct payment of insurance benefits to Huntsville Renal Clinic.

Financial Responsibility: I agree to pay all charges not covered by insurance, including co-pays, deductibles, and non-covered services.

HIPAA Notice: I acknowledge receipt of the Notice of Privacy Practices and understand how my health information may be used.

Authorized Representatives (persons permitted to discuss your care):

Name | Relationship | Phone | May access records?

☐ Yes ☐ No

Patient / Guardian Signature * | Printed Name | Date *

If signed by Guardian / Legal Representative, relationship to patient | Guardian Phone Number

For office use only: Date Received ____________ Verified by ____________ Chart # ____________ MRN ____________