

# MICHIGAN KIDNEY CONSULTANTS, P.C., PATIENT INFORMATION

Patient \_\_\_\_\_ Social Security # \_\_\_\_\_  
Last Name First Name Initial

Street Address \_\_\_\_\_

City/State/ZIP \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell/Work Phone \_\_\_\_\_

Referring Physician \_\_\_\_\_ Phone \_\_\_\_\_

If patient is a minor,  
Responsible Party \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Street Address \_\_\_\_\_ City/State/ZIP \_\_\_\_\_

Home Phone \_\_\_\_\_ Social Security # \_\_\_\_\_

Primary Insurance \_\_\_\_\_ Subscriber Name \_\_\_\_\_

Contract # \_\_\_\_\_ Group # \_\_\_\_\_ Subscriber Birth Date \_\_\_\_\_

Primary Insurance \_\_\_\_\_ Subscriber Name \_\_\_\_\_

Contract # \_\_\_\_\_ Group # \_\_\_\_\_ Subscriber Birth Date \_\_\_\_\_

Employment Status:  Employed  Unemployed  Student  Retired; date of retirement \_\_\_\_\_

Patient Employed By \_\_\_\_\_

Street Address \_\_\_\_\_ City/State/ZIP \_\_\_\_\_

Allergic to: \_\_\_\_\_

Notify in case of emergency \_\_\_\_\_ Phone \_\_\_\_\_

I understand that I am responsible for the payment of any and all charges for services rendered on my behalf. I understand that I am responsible for the payment of all co-pays and deductibles. I understand that any services not covered by my insurance will become my responsibility.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date