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

Patient Name $\frac{1}{Last}$			First		_Gender: Male	Female
Social Security #			Date of Birth			
Marital Status:	Single	Married	Divorced	Widowed	Separated	
Preferred Language: English Other (Please specify)						
American Indian or Alaska NativeNative Hawaiian or Other PaRace:AsianWhiteBlack or African AmericanPrefer Not to Say						fic Islander
Address	+			City	State	ZIP
Home Phone						
Alternate Phone						
Email						
Employment Status	s: Employed	Unen	nployed	Student Re	etired	
Current/Former Occupation:						
Do you have an Ad	vanced Care	Directive (L	<i>iving Will)</i> in	place? Yes	No	
Emergency Contact Phone						
If Patient is a mino	r, Responsible	e Party	Name		Rel	ationship
Address	t			City	State	ZIP
Social Security # _				Suy	Sinc	

I understand that I am responsible for 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.

Signature \_\_\_\_\_

Date

Michigan Kidney complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. ATTENTION: language assistance services, free of charge, are available to you. If you need these services, contact Gayle Robichaud 248-290-3111 ext 1713