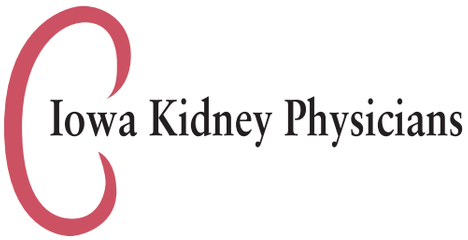

PATIENT REGISTRATION

Today's Date: _____

Patient Name: _____
(Please Print) *Last* *First* *Middle*

Date of Birth: _____/_____/_____ Marital Status: Married _____ Single _____ Widowed _____ Divorced _____

Sex: F_____ M _____ SSN: _____ - _____ - _____

Address: _____ Box or Apt. #: _____

City: _____ State: _____ Zip Code: _____

Home Phone: (_____) _____ Work Phone: (_____) _____

Cell Phone: (_____) _____ **PLEASE CIRCLE PRIMARY PHONE**

Email: _____ @ _____

When available would you like to be contacted for your upcoming appointments or other communication by:

Phone: _____ Web message: _____ Postal Mail: _____

Race: May choose more than one.
☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander ☐ White/Caucasian ☐ Refuse to Report

Ethnicity: May choose more than one.
☐ Hispanic or Latino ☐ Non-Hispanic or Latino ☐ Refuse to Report

Preferred Language: ☐ English ☐ Spanish ☐ Bosnian ☐ Vietnamese ☐ Laotian

Other: (please indicate) _____

Emergency Contact (not in your household) _____

Relationship _____ Phone (_____) _____

Person(s) we can speak to regarding your healthcare and billing:

1) Name: _____ Relationship: _____
2) Name: _____ Relationship: _____

Patient Name: _____ Date of Birth: _____/_____/_____

Person Responsible
For Account: _____ Date of Birth _____/_____/_____

SSN _____ - _____ - _____ Could Be *"Same as Above"*

Relationship To Paitent _____ Home Phone (_____) _____

Work Phone (_____) _____

Address _____ City _____ State _____ Zip _____

INSURANCE INFORMATION

Cardholder's Employer _____

Employer's Address _____

City _____ State _____ Zip _____

Primary
Insurance Co. _____ Group/Plan# _____ ID# _____

Relationship to Patient _____ Cardholder's Name _____

DOB _____ / _____ / _____

Secondary
Insurance Co. _____ Group/Plan# _____ ID# _____

Relationship to Patient _____ Cardholder's Name _____

IF YOU HAVE A THIRD COVERAGE NOTIFY THE RECEPTIONIST!

Referring Physician _____ Primary Physician _____

AUTHORIZATION FOR ASSIGNMENT OF BENEFITS AND INFORMATION RELEASE:

I HEREBY AUTHORIZE EXAMINATION AND TREATMENT DEEMED NECESSARY BY MY PHYSICIAN. I, THE UNDERSIGNED, AUTHORIZE AND ASSIGN PAYMENT OF MEDICAL BENEFITS TO WHICH I AM ENTITLED, TO MY PHYSICIANS FOR ANY SERVICES FURNISHED TO ME. I UNDERSTAND I AM FINANCIALLY RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY MY CONTRACT. I ALSO AUTHORIZE YOU TO RELEASE TO MY INSURANCE COMPANY INFORMATION CONCERNING HEALTH CARE, ADVICE, TREATMENT, OR SUPPLIES PROVIDED TO ME. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO THE CENTER FOR MEDICARE AND MEDICAID SERVICES AND ITS AGENTS ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR BENEFITS PAYABLE FOR RELATED SERVICES.

Patient/Responsible Party Signature: _____

Date: _____

Iowa Kidney Physicians, P.C. complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-515-241-5710.

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-515-241-5710。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-515-241-5710.