

**ARIZONA TRANSPLANT ASSOCIATES, PC**

James L. Cashman, MD, FACS
 Jeffrey A. Brink, MD, FACS
 Willem J. Van der Werf, MD, FACS
 Thomas Chaly, Jr., MD, FACS

2218 North Third Street
 Phoenix, Arizona 85004-1401
 Ph (602) 252-2543
 Fax (602) 252-3861

SCANNED(Office use only)**PATIENT REGISTRATION**

PLEASE PRINT CLEARLY AND COMPLETE ENTIRE FORM IN BLACK INK

PATIENT INFORMATION

Legal Name: _____
(FIRST) (MIDDLE) (LAST) (NICKNAME)

Mailing Address: _____ Apartment # _____

Physical Address: _____ Apartment # _____

City/State Zip: _____

Home #: _____ Cell #: _____ Work #: _____

Date of Birth: _____ Social Security #: _____

Male Female Transgender Single Married Partner Widowed Divorced

Primary Care (PCP) Name: _____

PCP Tel #: _____ PCP Fax #: _____

Referring Physician Name: _____

Referring MD Tel #: _____ Referring MD Fax #: _____

RESPONSIBLE PARTY OR GUARANTOR Self

Name: _____ Address: _____

Relationship: _____ City/State/Zip: _____

Date of Birth: _____ Social Security#: _____

Home #: _____ Work #: _____

PATIENT EMPLOYMENT INFORMATION

Employed Not employed Self-employed Active Military Duty Retired Disabled

Employer Name: _____ Employer Phone #: _____

RACE:		ETHNICITY:	LANGUAGE:
<input type="checkbox"/> American Indian or Alaska Native	<input type="checkbox"/> Hispanic	<input type="checkbox"/> Hispanic or Latin	<input type="checkbox"/> English
<input type="checkbox"/> Asian	<input type="checkbox"/> Other Race	<input type="checkbox"/> Not Hispanic or Latin	<input type="checkbox"/> Indian
<input type="checkbox"/> Native Hawaiian	<input type="checkbox"/> Other Pacific Islander	<input type="checkbox"/> Refused to Report	<input type="checkbox"/> Spanish
<input type="checkbox"/> Black or African American	<input type="checkbox"/> Refused to Report		<input type="checkbox"/> Russian
<input type="checkbox"/> White			<input type="checkbox"/> Other _____

INSURANCE INFORMATION (PLEASE COMPLETE ALL SECTIONS) KIDNEY DONOR FOR: _____**PRIMARY INSURANCE INFORMATION:**

Insurance Co. Name: _____

ID#: _____

Group/Policy #: _____

Subscriber Name: _____

Relationship to Patient: _____

Subscriber Employer: _____

Subscriber SSN: _____

Subscriber Date of Birth: _____

SECONDARY INSURANCE INFORMATION:

Insurance Co. Name: _____

ID#: _____

Group/Policy #: _____

Subscriber Name: _____

Relationship to Patient: _____

Subscriber Employer: _____

Subscriber SSN: _____

Subscriber Date of Birth: _____

☆ _____ Relationship to patient if minor _____ Date _____

PATIENT SIGNATURE (If patient is a minor, must have responsible party/guarantor sign)

Relationship to patient if minor

Date