ARIZONA TRANSPLANT ASSOCIATES, PC
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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 Physician 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:
☐ American Indian or Alaska Native	☐ Hispanic	☐ Hispanic or Latin	☐ English
☐ Asian	☐ Other Race	☐ Not Hispanic or Latin	☐ Indian
☐ Native Hawaiian	☐ Other Pacific Islander	☐ Refused to Report	☐ Spanish
☐ Black or African American	☐ Refused to Report		☐ Russian
☐ White			☐ Other_____

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

PRIMARY INSURANCE INFORMATION:	SECONDARY INSURANCE INFORMATION:
Insurance Co. Name: _____	Insurance Co. Name: _____
ID#: _____	ID#: _____
Group/Policy #: _____	Group/Policy #: _____
Subscriber Name: _____	Subscriber Name: _____
Relationship to Patient: _____	Relationship to Patient: _____
Subscriber Employer: _____	Subscriber Employer: _____
Subscriber SSN: _____	Subscriber SSN: _____
Subscriber Date of Birth: _____	Subscriber Date of Birth: _____

☆

_____ _____ _____

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