REDWOOD RENAL
ASSOCIATES

Patient Information Form		Today's Date:
First Name:	Last Name:	Date of Birth:
Street:	City:	State & Zip:
Sex: Male Female	Marital Status: Single/ Married/ Div/ Widow(er)	Social Security #
Primary Language:	Race/Ethnicity	Employer:
Best Way to Contact: Phone: Home:	Cell :	Work:
Best Days to Call:	Best Time to Call:	
If you are not available may we leave a message? Yes / No		
If you would you like to receive Appointment reminders by e-mail:		
In Case of Emergency, whom should we contact?		
Relationship to Patient:	Best Contact info:	
Who is your Primary Physician?		
Who is your Referring Physician?		

Insurance Information	
Primary Insurance:	Secondary Insurance:
Name on Card:	Name on Card:
Policy #	Policy #
Effective Date:	Effective Date:

Authorization		
I hereby authorize the release of Medical Information to Redwood Renal Associates for the purpose of providing medical care to myself. This authorization is limited as follows: Any records requested ☐ Any Records Except those relating to: Mental Health ☐ Drug & Alcohol ☐ HIV/AIDS ☐		
This authorization expires:	In 12 months	Never
Signature of Patient:		Date: