# Ohio Kidney Consultants

Patient Demographic Information

**Patient Name:** _____ **SS#:** _____

**Home Address:** _____

**City:** _____ **ST:** _____ **Zip:** _____

**Preferred Phone #:** _____ ☐ cell ☐ home ☐ work

**Alternate Phone #:** _____ ☐ cell ☐ home ☐ work

**Sex**: ☐ M ☐ F **DOB:** _____

**Race:** ☐ White ☐ Black ☐ Asian ☐ Pacific Islander ☐ American Indian

☐ Other (please specify): _____

**Ethicity:** ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Unknown

**Language:** ☐ English ☐ ASL ☐ Spanish ☐ Hindi ☐ Arabic ☐ Chinese ☐ Japanese

☐ Other (please specify): _____

**Do you need an interpreter for appointments?** ☐ Yes ☐ No

**Marital Status:** ☐ Single ☐ Married/Partner ☐ Divorced ☐ Widowed

**Primary Care Dr:** _____ **Phone:** _____

**Employer:** _____

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**Emergency Contact:** _____ **Phone:** _____

**Relationship to Patient:** _____

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## If your insurance is carried through a spouse or parent, please enter their information:

**Name:** _____ **SS#:** _____

**DOB:** _____ **Relationship to patient:** _____

**This pertains to:** ☐ Primary Insurance ☐ Secondary Insurance ☐ Both

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## Responsible party for insurance and bills, if other than patient:

**Name:** _____ **Phone #:** _____

**Address:** _____

**City:** _____ **ST:** _____ **Zip:** _____

**Relationship to Patient:** _____