Northwest RENAL Clinic, Inc.

Patient Registration Form

Patient Name: (Last)_____ (First) _____ (MI) _____

Aliases: _____ **Date of Birth:** ___/____/____ **Email:** _____

Mailing Address: _____

City: _____ **State**: _____ **Zip**: _____

Home phone: _____ **Work phone:** _____

Mobile Phone: _____ **Fax:** _____

Secondary contact / emergency contact: _____

Relationship to patient: _____ **Phone number:** _____

Preferred method of contact: ☐ Telephone – text yes/no ☐ Telephone – V/M yes/no ☐ Email
(Select all that apply)

Sex:	☐ Female | ☐ Male |☐ Nonbinary | ☐ Other | ☐ Unknown
Gender Identity:	☐ Choose not to disclose | ☐ Female | ☐ Male | ☐ Transgender Female ☐ Transgender Male | ☐ Not listed
Sexual Orientation:	☐ Choose not to disclose | ☐ Bisexual | ☐ Lesbian | ☐ Gay ☐ Not listed | ☐ Straight

Current Marital Status: ☐ Single | ☐ Married | ☐ Divorced | ☐ Widowed | ☐ Separated

Ethnicity: ☐ Hispanic or Latino ☐ Non-Hispanic or Latino ☐ Other or Undetermined

Preferred Language: _____

Primary Care Physician Name: _____**Phone:** _____

Referring Physician Name: _____**Phone:** _____

Preferred Pharmacy: _____

Preferred outpatient lab location: _____