Southern Indiana Nephrology & Hypertension, PC

Patient Registration

Name:_____ **Date**:_____

Address:_____ **Phone**: (_____) _____

Cell

_____ **Phone**: (_____) _____

Date of Birth: _____ **Social Security Number:** XXX- XX- _____

Gender: ☐ Not disclosed
☐ male
☐ female

Ethnicity: ☐ Not disclosed
☐ Hispanic or Latino
☐ Non- Hispanic or Latino

Race: ☐ Not disclosed
☐ American Indian or Alaska Native
☐ Asian
☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander
☐ White

Primary **Language:**
☐ English ☐ Mandarin
☐ Japanese ☐ Spanish
☐ Other:_____

Employer: _____ Phone: (_____) _____

Type of work or job title: _____

Emergency Contact _____ Phone: (_____) _____

Notice Receipt Acknowledgement

I acknowledge that I have received the Southern IN Nephrology & Hypertension (SINH) Notice of Privacy Practices. I have had the full opportunity to read and consider the contents of this Notice of Privacy Practices.

In addition to my physicians, healthcare service providers, and insurance carriers,

I authorize SINH to release pertinent medical information to:

Name	**Relationship**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Patient's Signature: _____ **Date**: _____

_____

If this registration, authorization is signed by a **personal representative** on behalf of the individual, complete the following:

Personal Representative's Name _____

Relationship to Patient _____

Signature _____ Date _____