KIDNEY AND HYPERTENSION CARE CENTER, PA 1213 Hermann Dr., Suite 460, Houston, Texas 77004 •Tel: (713) 520-6222 •Fax: (713) 520-6223

L213 Hermann Dr., Suite 460, Houston, Texas 77004 •Tel: (713) 520-6222 •Fax: (713) 520-6223 Monday – Friday: 8:00 am to 5:00 pm, For after hours support dial our office phone number Email:ggarza@kidneyspecialist.org

NEW PATIENT REFERRAL FORM

PATIENT INFORMATION

*Patient Last Nam	ne					
*Patient First Nan	ne		Patient M.I			
*Patient Contact I	Numbers	5:				
Home:			V	/ork:		
(xxx-xxx-xx	xx)			(xxx-xxx-xxxx)	
Cell:			Email:			
(xxx-xxx-x	(XX)				
*Date of Birth		l	l	_ *Social Security	No	
M	onth	Day	Year			
*Address						
City	l_		State	Zip Code	Phone Number	
City			State	Zip code	Thone Nomber	
*Patient Diagnosis	S		·			
Dationt Labo						
Patient Labs						
*Primary Insuran	ce	Drimanulacurar	aca campany Nama	,,	type, PPO, HMO, Medicare, Medicaid	
		Primary insurar	ice company Name	insurance	type, PPO, HIMO, Medicare, Medicare	
*Group Number		,		*Member ID Number		
•	6 .					
*Primary Insuran	ce Conta	act Numbers	S			
	Of	fice:		Fax:	(van van van v	
			(xxx-xxx-xxxx)		(xxx-xxx-xxxx)	

*Secondary Insurance		,				
Secondary	Insurance ty	Insurance type, PPO, HMO, Medicare, Medicaid				
*Group Number	*Member ID Number					
*Secondary Insurance Contact Nu	umbers					
Office:		Fax:				
	(xxx-xxx-xxxx)		(xxx-xxx-xxxx)			
If insurance is under som	neone other tha	an the patien	nt			
*Policyholder Name (Last, First, Middle)						
Group Number	,	lember ID Number				
*Date of Birth	*Soc	ial Security No _				
Month Day		,				
*Address						
1	1 1					
City		Zip Code	Phone Number			
*Relationship to patient	, *Emplo	yer Name				
*Required Fields						
FAX COMPLETED FORM TO	0 (713) 520-62	223 or				
Email scanned copy of fo	rm to: ggarza@	kidneyspeci	alist.org			
FOR OFFICE USE ONLY						
DR #	, Office					
DR	, Appt Date	, Appt T	ime			
Follow-up Appointment Date		. Appt Time	e			