University of Washington Transplant Services
Patient Demographic Information – Kidney/Pancreas

Last Name: _____ Date: _____

First Name: _____ Middle Name: _____

Name you prefer to be called: _____

Maiden Name (If applicable): _____

Circle One: Mr. Mrs. Miss. Ms. Dr.

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Other Phone: _____

Social Security Number: _____ Date of Birth: _____

Gender: [ ] Male [ ] Female

Citizenship: [ ] United States Citizen [ ] Resident Alien [ ] Non-resident Alien [ ] Other [ ] Unknown

LEGAL NEXT OF KIN

Name: _____ Relationship to you: _____

Address: _____

City, State, Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

PERSON TO NOTIFY IN CASE OF AN EMERGENCY

Name: _____ Relationship to you: _____

Address: _____

City, State, Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

EMPLOYER

Name: _____

Address: _____

City, State, Zip: _____

Work Phone: _____ Work Extension: _____

INSURANCE INFORMATION

Guarantor (person who will pay for your care if you are not covered by insurance)

Name: _____

Address: _____

City, State, Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Primary Insurance Name: _____

Phone Number: _____ Policy ID Number: _____

Subscriber Name: _____ Subscriber Employer: _____

Subscriber Social Security Number: _____

Group Name: _____ Group Number: _____

Secondary Insurance Name: _____

Phone Number: _____ Policy ID Number: _____

Subscriber Name: _____ Subscriber Employer: _____

Subscriber Social Security Number: _____

Group Name: _____ Group Number: _____

PHYSICIAN WHO REFERRED YOU TO THE UW MEDICAL CENTER

Name: _____

Address: _____

City, State, Zip: _____

Office Phone: _____ Office Fax: _____

Physician Specialty: [ ] Nephrology (Kidney) [ ] Endocrinology (Diabetes)

[ ] Other [ ] Gastroenterology (Stomach) [ ] Hepatology (Liver)

PRIMARY CARE PHYSICIAN

Name: _____

Address: _____

City, State, Zip: _____

Office Phone: _____ Office Fax: _____

Physician Specialty: [ ] Nephrology (Kidney) [ ] Endocrinology (Diabetes)

[ ] Other [ ] Gastroenterology (Stomach) [ ] Hepatology (Liver)

OTHER MEDICAL SPECIALIST INVOLVED IN YOUR CARE

Name: _____

Address: _____

City, State, Zip: _____

Office Phone: _____ Office Fax: _____

Physician Specialty: [ ] Nephrology (Kidney) [ ] Endocrinology (Diabetes)

[ ] Other [ ] Gastroenterology (Stomach) [ ] Hepatology (Liver)

KIDNEY DIALYSIS CENTER YOU ATTEND

Name of Kidney Center: _____

Name of Contact Person (Nurse, Director, etc.): _____

Address: _____

City, State, Zip: _____

Office Phone: _____ Office Fax: _____

HIGHEST EDUCATIONAL LEVEL

[ ] None [ ] Grade School (0-8) [ ] High School (9-12) [ ] Associate/Bachelor's Degree

[ ] Unknown [ ] Attended College/Technical School [ ] Post-College Graduate School