Advanced Renal Care Ltd.
Kidney Diseases, Hypertension and Renal Transplant

Patients Name_____
Last First Middle
Date of Birth_____/_____/_____Social Security #____-___-_____ Sex___
Address_____
City_____ State_____ Zip_____
Home Phone #_____ Work Phone #_____
Patient's employer_____ Telephone #_____
Spouse Name _____Telephone #_____

Race: White/ Caucasian □ Hispanic □ Asian □ African American □ Native Hawaiian or Other □

EMERGENCY CONTACT INFO

Notify in case of emergency name and number_____/_____

Family Physician _____Telephone #_____

Insurance Information

Primary Insurance Company_____
Insured Name _____ Effective Date of policy_____
Policy #_____ Group #_____
Primary Insurance Mailing address_____
Zip Code_____ Telephone # _____

Secondary Insurance Company_____
Insured's Name _____ Effective date of policy_____
Policy # _____Group # _____
Secondary Insurance Mailing Address_____
Zip Code _____Telephone # _____

Our office will require a copy of your insurance card(s) for our records.

I authorize the release of all medical information necessary to process my claims for services provided by Anis A. Rauf, DO, Mohammed S. Ahmed. I also request that payment for these services by made directly to Advanced Renal Care, LTD at 2340 S. Highland Ave. Suite 160, Lombard, IL 60148.

Patient Signature _____Date_____
Parent's Signature (if minor) _____