



**THE ROGOSIN INSTITUTE**  
Centers For Medical Research And Health Care

**Transient/Transfer Dialysis Patient  
Form # 2 (Intake Information)**

Patient Name: \_\_\_\_\_

SSN: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

First Dialysis: \_\_\_\_\_ Transplant: Y N Date: \_\_\_\_\_ Disabled: Y N Date: \_\_\_\_\_

Employer Name & Address: \_\_\_\_\_

\_\_\_\_\_

Have you applied for Medicare Coverage? Y N

Policy Holder: Self Other Relationship: \_\_\_\_\_

Policy Holder Information (other than patient):

Name: \_\_\_\_\_

SSN: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Employed: Y N Retired: Y N Date: \_\_\_\_\_ Disabled: Y N Date: \_\_\_\_\_

Employer Name & Address: \_\_\_\_\_

\_\_\_\_\_

Insurance Information: \_\_\_\_\_

\_\_\_\_\_

Emergency Contact Name & Phone: \_\_\_\_\_

\_\_\_\_\_

Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_