

Patient Financial Profile

CONFIDENTIAL

Patient's Name *

First Name Last Name

Patient Date of Birth

#

Month Day Year

Phone Number

Area Code Phone Number

Date of Transplant

=

Month Day Year

Date of First Dialysis Treatment

#

Month Day Year

Insurance Information

Private Insurance

AHCCCS.

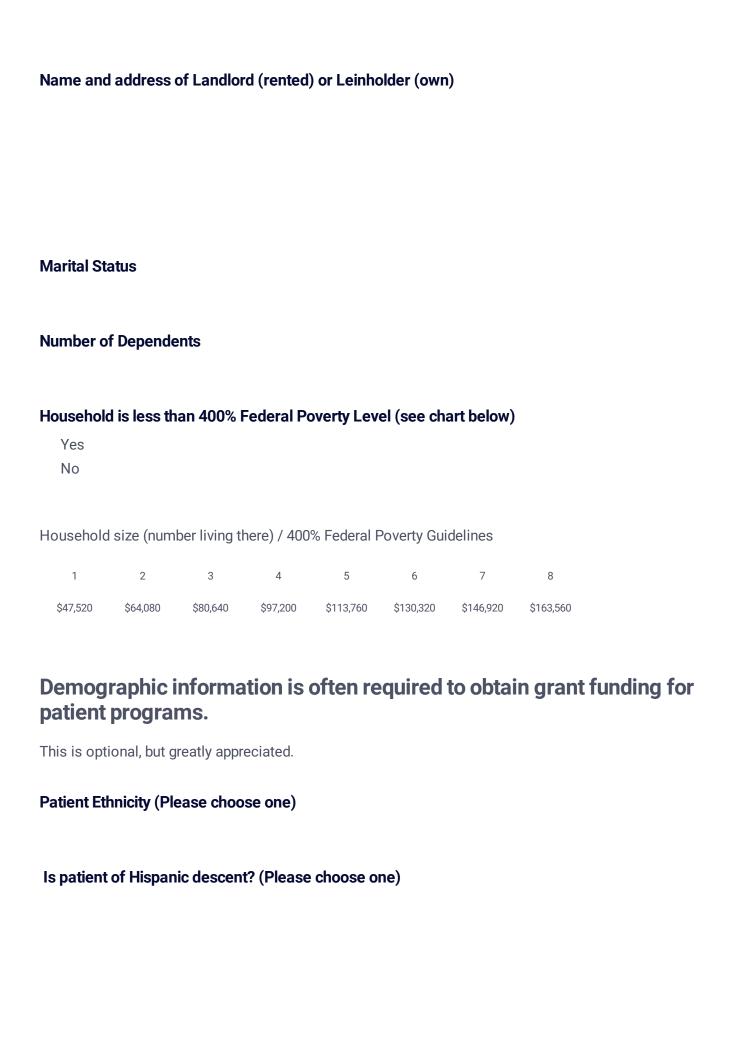
Medicare

VA Coverage

No Coverage

Insurance Carrier Name

Insurance Expiration Date				
Month Day Year				
Treatment Facility				
Address				
Street Address				
Street Address Line 2				
City	State / Province			
Postal / Zip Code				
How long at current address?				
Hama ia				
Home is:				
Rented				
Owned				



Please select all that apply Date Month Day Year Unit Representative Name First Name Last Name Position

Patient is an enrolled member of the following tribal community, village, reservation or nation:

-

Year

Date

Month Day



Dental Care Application

Date			
			m.
Month	Day	Year	
Treatn	nent Fa	cility	
Patien	t Name		
First Nar	ne	Last Name	
Date o	f Birth		
Month	Day	Year	
Is a cu	rrent Pa	atient Fina	ncial Profile on file
Yes	;		
No			
Does t	he patie	ent have A	HCCCS or ALTCS health insurance?
Yes	;		
No			
Does t	he patio	ent have d	ental insurance of any kind?
Yes	;		
No			

Statement of Financial Need				
Social Worker Name				
First Name Last Name				
Statement of Need for Dental Care - Patient is preparing for transplant?				
outement of Need for Dental Care if attent is preparing for transplant.				
If No, please attach a letter from the renal dietician or the patient's nephrologist that documents how the need for dental care is compromising the patient's health				
If Yes, identify Transplant Center				
Transplant candidates in need of dental clearance are encouraged to complete all other testing before applying unless they have oral pain or infection.				
Has all other testing been completed to clear patient for transplant?				
If no, does the patient have oral pain or infection?				

Nephrologist Name

