Medical City
Transplant Institute | Dallas

PEDIATRIC TRANSPLANT APPLICATION

Type of Transplant:
❑ Kidney
❑ Heart/Kidney

PATIENT INFORMATION

Name:	Date of Birth:	Sex: ❑ Male ❑ Female
Social Security #:	Height:	Weight:
U.S. Citizen: ❑ Yes ❑ No	Resident Alien: ❑ Yes ❑ No	Language Preference:
Address: Apt#	City: State:	Zip:
Name of Parent/Guardian:	Phone#:	Cell#:
Email:	Emergency Contact:	Phone#:

MEDICARE/MEDICAID INFORMATION *(Please include a copy of all insurance cards)*

Medicare ID #:	Effective Date:
Medicaid ID #:	Effective Date:
Texas Kidney Health Plan#:	Date of First Dialysis:

INSURANCE INFORMATION	SECONDARY INSURANCE INFORMATION
Insured Name:	Insured Name:
Insurance Co. #:	Insurance Co. #:
Customer Service #:	Customer Service #:
Policy# / I.D.# Group#	Policy# / I.D.# Group#
Address:	Address:
City: State: Zip:	City: State: Zip:
Effective Date:	Effective Date:

REFERRING AGENTS

Referring Physician:	Group Practice Name:
Address:	City: State: Zip:
Phone #:	Fax #:
Name of Dialysis Center:	Phone Number:
Dialysis Center Social Worker:	
Type of Dialysis: ❑ Not yet on dialysis ❑ Peritoneal ❑ Hemodialysis	
Hemodialysis Days: ❑ M/W/F ❑ T/Th/Sat	Dialysis Time:
Previous Transplant: ❑ Yes ❑ No	If Yes, Location: Date:

RELEASE OF INFORMATION - Patient Request to Begin Evaluation and Financial Clearance Process:

I request that Medical City Dallas Transplant Center begin the financial clearance process and transplant evaluation for me. I understand that my insurance companies will be contacted in order to start the transplant process. I authorize my physicians to release my medical records to Medical City Transplant Center. I authorize Medical City Transplant Center to release any medical information pertaining to my diagnosis and/or treatment, including by not limited to, information concerning communicable diseases such as Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS), laboratory test results, medical history, treatment, or any other such related information to: 1) Medicare; 2) Medicaid; 3) my insurance company or it's designated representatives; 4) any person (s) or entities financially responsible for my care or treatment. The duration of this authorization is indefinite. I understand that this information may be required to be released in order to obtain payment for my medical expenses incurred at Medical City Transplant Center. I further authorize release of this information to health care providers associated with my care outside of Medical City Transplant Center.

Parent/GuardianSignature: _____ Witness Signature: _____

Print Name: _____ Date: _____ Print Name: _____ Date: _____

REQUIRED DOCUMENTS	*(Please include a copy of the following required documents)*
❑	Copy of the front and back of all insurance cards
❑	Copy of your social security card
❑	Copy of your Texas I.D. or drivers license (if available)
❑	Copy of your resident alien card (if applicable)
❑	Copy of all immunization records

FAX REFERRAL FORM TO: 972.566.4872

Mail completed application to:
Medical City Dallas
Transplant Services
7777 Forest Lane, Bldg. C-750
Dallas, Texas 75230
1-800-348-4218