TEXOMA NEPHROLOGY & HYPERTENSION CLINIC

YASIR LAL, MD

4616 US-75, SUITE 203 * DENISON, TX 75020

Phone: 903-841-4454 * Fax: 903-730-6392

Last Name: _____ First Name: _____ MI: ____

Home Address: _____ City_____ State _____ Zip_____

Cell phone#: _____ Alternate phone#: _____

Email address: _____

SS# _____ DOB: _____ Gender: Male____ Female ___

Marital Status: Single __ Married __ Divorced __ Widow(er) __

Spouse Name: _____ DOB_____ SS#_____

Employer Name: _____ Employer Phone#:_____

Ethnicity: Caucasian__Black__Asian__Hispanic__Native American__Other:_____

Pharmacy Name (short term meds) _____ Phone#:_____

Pharmacy Name (long term meds)_____Phone #:_____

Primary Care Physician: _____ Phone #:_____

Referring Physician: _____Phone #:_____

In case of Emergency, please list someone other than yourself, their contact number, and relationship.

Name:_____ Phone#:_____

Relationship:_____

Power of Attorney:_____ Phone#:_____

Primary Insurance:

_____

Member ID#_____

Member Name: _____

Member DOB:_____

Secondary Insurance:

_____

Member ID#_____

Member Name:_____

Member DOB:_____

Signature of patient/guardian/responsible party Date

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Consent To Use and Disclosure of Protected Health Information

Use and Disclosure of Your Protected Health Information

Your protected health information will be used by **Texoma Nephrology & Hypertension Clinic o**r disclosed to others for the purpose of treatment, obtaining payment, or supporting the day-to-day health care operations of the patients.

Notice of Privacy Practices

You should review the Notice of Privacy Practice for more complete description of how your protected health information may be used or disclosed. You may review the notice prior to signing this consent.

Requesting a Restriction on the Use or Disclosure of Your Information

You may request a restriction on the use or disclosure of your protected health information.

Texoma Nephrology & Hypertension Clinic may or may not agree to restrict the use or disclosure of protected information.

If **Texoma Nephrology & Hypertension Clinic** agrees to your request, the restriction will be binding on the practice. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent

You may revoke this consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to this date on which your revocation of consent is received will not be affected.

Reservation of Right to Change Privacy Practices

Texoma Nephrology & Hypertension Clinic reserves the right to modify the privacy practices outlined in the notices.

Signature

I have reviewed this consent form and given my permission to Texoma Nephrology & Hypertension Clinic to use and disclose my health information in accordance with it.

_____ _____

Signature of Patient **Signature of Patient Representative**

_____ _____

Name of Patient (Print) **Relationship to Patient**

_____

Date

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HIPAA Disclosure Form

Patient Name : _____ Date : _____

Listed Address : _____

Phone Number : _____

Email Address : _____

Would you like our correspondence to you marked as Confidential? Yes___ No___

May we leave messages? Yes ___ No___

I, the Patient, hereby authorize the doctor and/or hospital listed above to release my medical information (appointments, lab/x-ray results, diagnoses, treatments, medications, surgeries, etc.) via postal mail, telephone, fax, or email to the following family members/friends:

Name: _____DOB:_____Relationship:_____

Name: _____DOB:_____Relationship:_____

Name: _____DOB:_____Relationship:_____

Name: _____DOB:_____Relationship: _____

Name: _____ DOB:_____Relationship:_____

_____ _____

Patient Signature Date

MEDICATION LIST

Do you have any DRUG allergies? Yes____ No____

If so, please list here: _____

_____

PLEASE LIST ALL MEDICATIONS (INCLUDING OVER THE COUNTER ONES):

_____ _____

Signature **Date**

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MEDICAL HISTORY: Please indicate yes or no on each of the following illnesses. If you have had any of these, please tell us the duration that you have had it.

Name of Illness	Yes or No	Duration	Name of Illness	Yes or No	Duration
Diabetes			Chronic Kidney Disease		
Hypertension			Kidney Stones		
Heart Disease			UTI		
A-fib			Depression		
Cholesterol			Anxiety		
Bleeding Disorders			Bipolar Disorder		
Blood Clots			Others:		
Chronic Infections					
Kidney Failure					

SURGERIES

	Yes or No	Date of Surgery		Yes or No	Date of Surgery
Gall Bladder			Stomach		
Kidney			Prostate		
Colon			Heart		
Hernia			Thyroid		
Any other Surgeries					

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FAMILY HISTORY

Please make a CHECK MARK in all boxes that apply:

	Kidney Disease	Diabetes	High Blood Pressure	Dialysis	Heart Disease	Cancer	Lung Disease
Father							
Mother							
Paternal Grandfather							
Paternal Grandmother							
Maternal Grandfather							
Maternal Grandmother							
Siblings: Total Brothers: ___ Total Sisters: ___							

SOCIAL HISTORY

	CURRENTLY USE	TYPE	FREQUENCY & AMOUNT	IF QUIT, WHEN?
ALCOHOL USE				
SMOKING				
DRUG USE				

REVIEW OF SYSTEMS

GENERAL

Recent weight loss ____yes____no
Fever/chills ____yes____no
Feeling tired ____yes____no
Recent weight gain ____yes____no
Weakness ____yes____no

HEAD, EARS, EYES, NOSE, THROAT

Hoarseness ____yes____no
Oral ulcers ____yes____no
Sore throat ____yes____no
Bad breath or taste ____yes____no
Headaches ____yes____no
Blurred or
Double Vision ____yes____no
Sinus problems ____yes____no

CARDIOVASCULAR

Chest pain/angina ____yes____no
Palpitations ____yes____no
Swelling of feet
ankles,hands ____yes____no
Hypertension ____yes____no
Shortness of breath ____yes____no

RESPIRATORY

Chronic cough ____yes____no
Shortness of breath ____yes____no
Wheezing ____yes____no
Coughing of blood ____yes____no

GASTROINTESTINAL

Difficulty swallowing ____yes____no
Poor appetite ____yes____no
Nausea ____yes____no
Frequent Diarrhea ____yes____no
Painful bowel
movements ____yes____no
Blood in Stool ____yes____no
Constipation ____yes____no
Abdominal pain ____yes____no
Black/Tarry Stool ____yes____no
Vomiting ____yes____no

MUSCULOSKELETAL

Joint pain, multiple ____yes____no
Joint stiffness ____yes____no
Back pain ____yes____no
Muscle aches ____yes____no
Muscle cramps ____yes____no

PSYCHIATRIC

Anxiety ____yes____no
Depression ____yes____no

SKIN

Rashes ____yes____no
Skin lesions ____yes____no
Wounds ____yes____no

NEUROLOGICAL

Tingling ____yes____no
Seizures ____yes____no
Numbness ____yes____no
Headaches ____yes____no
Balance problem ____yes____no
Dizziness ____yes____no

ENDOCRINE

Hair Changes _____yes____no
Heat/Cold intolerance _____yes____no
Excessive urination _____yes____no
Changes in appetite _____yes____no

HEMATOLOGIC/LYMPHATIC

Easy Bruising ____yes____no
Anemia ____yes____no
Phlebitis ____yes____no
Transfusions ____yes____no
Easy Bleeding ____yes____no
Prolonged Bleeding ____yes____no

GENITOURINARY

Frequent urination 7+ ____yes____no
Burning or painful
urination ____yes____no
Blood in urine ____yes____no
Nocturia 2+ times
at night ____yes____no
Frothy/Foamy urine ____yes____no
Urinary incontinence ____yes____no