

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: _____

Secondary Insurance: _____

Member ID# _____

Member ID# _____

Member Name: _____

Member Name: _____

Member DOB: _____

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** or 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: _____

Patient 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