KIDNEY AND HYPERTENSION
ASSOCIATES OF DALLAS

Patient Information
(Please Print)

Referred to clinic by **(please check one box):**

❑ Dr._____ ❑ Insurance Plan ❑ Hospital ❑ Family ❑ Friend ❑ Other_____

Primary Care Physician: _____

Name: _____
(Last) **(First)** **MI**

DOB: _____ **Age:** ____ **SS#** _____**Ht:**_____ ❑**M** ❑**F** **Status:** ❑ **S** ❑ **M** ❑ **D** ❑ **W**
Address:

_____
(Street)

_____
(City) **(State)** **(Zip)**

Home Phone:_____ **Cell Phone**_____

Email_____

Employment
Employer: _____ **Work Phone:(_____)**_____

Emergency Contact

_____**(_____)**_____
(Name) **(Phone)** **(Relationship)**

Primary Insurance Company:_____

Insurance Address:_____

Policy #_____ **Group #**_____

Cardholder:_____ **Insurance Phone :**_____

Secondary Insurance Company:_____

Insurance Address:_____

Policy #_____ **Group #**_____

Cardholder: _____ **Insurance Phone:** _____

I herby consent to treatment by the physicians and/or associates of Kidney and Hypertension Associates of Dallas.
Signature: _____**Date:**_____
I herby assign my insurance benefits to be paid directly to Kidney and Hypertension Associates of Dallas
I understand that I am financially responsible for all charges not covered by this assignment.
Signature: _____**Date**_____

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HEALTH HISTORY

Name: _____ **DOB:** _____

Preferred Local Pharmacy: _____ **Ph.:** _____ **Fax:** _____

Mail Order Pharmacy: _____ **ID # :** _____ **Ph.:** _____

Current Medications

Medication	Dose	How often	Medication	Dose	How often

Do you take? ☐ Herbal Products ☐ Vitamins ☐ Nutrition supplements ☐ NSAIDs (Advil, Motrin, etc)

Allergies ☐ No ☐ Yes (list allergies below)

Medication	Reaction (Rash, hives, etc)	Medication	Reaction (Rash, hives, etc)

Current Medical History (indicate below)

☐ High blood pressure	☐ Diabetes	☐ Asthma	☐ Kidney Stones
☐ Heart Attack	☐ Cancer _____	☐ Emphysema	☐ Urinary Tract Infection
☐ Heart Disease (other)	☐ HIV/AIDS	☐ Anemia	☐ Other Kidney Disease
☐ Stroke	☐ Thyroid Disease	☐ Sickle Cell Disease	☐ Liver Disease

☐ Other

Past Surgeries (list with year of surgery)

Surgery	Date	Surgery	Date

Family History

Relation	Living?	Age	High BP	Heart Dis.	Stroke	Cancer	Kidney Problems	Other (describe)
Father	Y / N		☐	☐	☐	☐	☐	
Mother	Y / N		☐	☐	☐	☐	☐	
Brother/Sister								
M / F	Y / N		☐	☐	☐	☐	☐	
M / F	Y / N		☐	☐	☐	☐	☐	
M / F	Y / N		☐	☐	☐	☐	☐	
Children								
M / F	Y / N		☐	☐	☐	☐	☐	
M / F	Y / N		☐	☐	☐	☐	☐	
M / F	Y / N		☐	☐	☐	☐	☐	

Other disease in your family? (check those that apply)

☐ Asthma	☐ Sickle Cell	☐ Leukemia	☐ Other
☐ Diabetes	☐ Thyroid problem	☐ Bleeding problem	

Social History

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other Occupation _____

Do you use tobacco? Yes / No / Quit ☐ Cigarettes ☐ Cigars ☐ Chewing Tobacco ☐ Snuff How Much? _____

Do you drink alcohol? Yes / No / Quit ☐ Beer ☐ Wine ☐ Mixed Drinks How many drinks per week? _____

Recreational drug use? Yes / No / Quit

Review of Systems

General	Weight Loss / Gain	☐ Yes	☐ No	Fevers / Chills	☐ Yes	☐ No
	Loss of Appetite	☐ Y	☐ N	Night Sweats	☐ Y	☐ N
	Fatigue	☐ Y	☐ N			
Eyes	Glasses or contacts	☐ Y	☐ N	Blurry Vision	☐ Y	☐ N
	Glaucoma	☐ Y	☐ N	Cataracts	☐ Y	☐ N
ENT	Hearing difficulty	☐ Y	☐ N	Ringing in ears	☐ Y	☐ N
	Nosebleeds	☐ Y	☐ N	Sinus problems	☐ Y	☐ N
	Sore throat / Mouth sores	☐ Y	☐ N	Difficulty swallowing	☐ Y	☐ N
	Hoarseness / Voice change	☐ Y	☐ N	Unusual or metallic taste	☐ Y	☐ N

Cardio	Chest pain / tightness	□ Y	□ N	Shortness of breath	□ Y	□ N
	Irregular heartbeat	□ Y	□ N	Difficulty walking stairs / hill	□ Y	□ N
	Swelling in hands or feet	□ Y	□ N	Leg pain /cramps with walking	□ Y	□ N
Respiratory	Persistent Cough	□ Y	□ N	Wheezing	□ Y	□ N
	Blood in sputum	□ Y	□ N	Exposure to tuberculosis	□ Y	□ N

GI	Nausea / vomiting	□ Y	□ N	Diarrhea	□ Y	□ N
	Black or bloody stools	□ Y	□ N	Constipation	□ Y	□ N
	Frequent heartburn	□ Y	□ N	Hemorrhoids	□ Y	□ N
Urinary	Blood in urine	□ Y	□ N	Foamy urine	□ Y	□ N
	Burning with urinating	□ Y	□ N	Straining to urinate / weak stream	□ Y	□ N
	Urinate more that once at night	□ Y	□ N	Kidney stone	□ Y	□ N
	Frequent kidney infections	□ Y	□ N	Leaking bladder	□ Y	□ N
Musculo-Skeletal	Muscle pain or weakness	□ Y	□ N	Bone / Joint pain	□ Y	□ N
	Arthritis	□ Y	□ N	Gout	□ Y	□ N
Skin	Rashes / Sores	□ Y	□ N	Abnormal moles / pigment	□ Y	□ N
Neurologic	Seizures	□ Y	□ N	Numbness	□ Y	□ N
	Headaches	□ Y	□ N	Dizziness/vertigo/balance prob.	□ Y	□ N
Psychiatric	Depression	□ Y	□ N	Trouble sleeping	□ Y	□ N
	Suicidal thoughts	□ Y	□ N	Mood disorders	□ Y	□ N
Hematologic	Easy bruising	□ Y	□ N	Bleeding/clotting problems	□ Y	□ N
	Anemia	□ Y	□ N	Abnormal lymph nodes	□ Y	□ N
Endocrine	Excess thirst	□ Y	□ N	Heat or cold intolerance	□ Y	□ N
	Recent hair loss or growth	□ Y	□ N	Low / High blood sugars	□ Y	□ N
MEN Only	Erection difficulties	□ Y	□ N	Penile discharge	□ Y	□ N
	Testicle pain	□ Y	□ N	Testicle mass	□ Y	□ N
WOMEN Only	Abnormal PAP	□ Y	□ N	Vaginal discharge	□ Y	□ N
	Breast lump/mass/discharge	□ Y	□ N	Hot flashes	□ Y	□ N

Signature of person providing History:_____**Date:**_____

Relationship to Patient:(please circle) **Self / Spouse / Son / Daughter / POA / Guardian / Other:**_____

Kidney and Hypertension Associates of Dallas

PRIVACY PRACTICES NOTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.

Summary of Privacy Practices

We may use and disclose your medical information, without your permission, for treatment, payment, and health care operations activities and, when required or authorized by law, for public health and interest activities, law enforcement, judicial and administrative proceedings, research, and certain other public benefit functions.

We may disclose your medical information to your family members, friends, and others you involve in your health care or payment for health care, and to appropriate public and private agencies in disaster relief situations.

We will not otherwise use or disclose your medical information without your written authorization. You have the right to examine and receive a copy of your medical information, to receive an accounting of certain disclosures we may make of your medical information, and to request that we amend, further restrict use and disclosure of, or communicate in confidence with you about your medical information.

Please review this entire notice for details about the uses and disclosures we may make of your medical information, about your rights and how to exercise them, and about complaints regarding or additional information about our privacy practices.

Please specify the name of family or friends that the practice can speak with regarding medical or financial information.

Name	Contact #	Relationship	Date
1.			
2.			
3.			
4.			

Patient Name: _____ **DOB:** _____

Signature: _____ **Date:** _____

Signature if not patient: _____ **Date:** _____

Authorization For Release of Medical Records

Kidney and Hypertension Associates of Dallas
3417 Gaston Avenue
Suite 875
Dallas, Texas 75246

PHONE: *972-388-5970* **FAX:** *972-388-5971*

Patient Name_____

SS#:_____ **DOB:**_____

Receive Records From:
Please leave this section blank

_____
_____
_____
_____

Release Records To:
Please leave this section blank

_____
_____
_____
_____

Please send a copy of my records as indicated for date(s) of treatment: _____

Hospital Records____Lab Reports____Imaging Reports_____Office Notes____All Records_____

Purpose for releasing medical information:_____

_____

_____

Signature of Patient/Legal Guardian **Date**

Please provide the name of all other physicians you are under the care of so we may keep them informed of your progress.

Pt._____SS#_____-_____-_____
DOB:____/____/____

Dr._____ Primary Care Provider
Phone :_____ Fax:_____

Dr._____ Specialty_____
Phone :_____ Fax:_____

Dr._____ Specialty_____
Phone :_____ Fax:_____

Dr._____ Specialty_____
Phone :_____ Fax:_____

Dr._____ Specialty_____
Phone :_____ Fax:_____

Dr._____ Specialty_____
Phone :_____ Fax:_____

Dr._____ Specialty_____
Phone :_____ Fax:_____

X_____Date_____

Pt. signature authorizes release/request of records between KAH Dallas and above listed doctors only.

____Not under care of any other doctors.

I understand that Kidney and Hypertension Associates of Dallas utilizes electronic health records software which incorporates ePrescribing technology. I understand and (**agree/do not agree**) that Kidney and Hypertension Associates of Dallas may access and use my prescription history through ePrescribing software for the purpose of providing continuing and ongoing care.

Signature Date