CT Kidney and Hypertension Specialists

www.ctkidneyspecialists.com

New Patient Forms

Name____________________
DOB___________________

Please complete section completely

Name:________________________ ____________________ ________ Sex: ☐ F ☐ M
Last First MI

Address:____________________________________ City:_____________ Zip Code:_________________

Phone Number: CELL______________ ☐ if Preferred HOME:__________________ ☐ if Preferred

Employer: ______________________________________Work Phone:___________________________
Name Address

EMAIL ADDRESS:______________________________ Social Security Number:___________________

Emergency Contact Person: ______________________________ Phone:__________________________

Preferred Pharmacy:____________________________________ Check here if ☐ Mail Order
Name Town/City

Primary Physician/Provider: ___________________Insurance:___________________________________

Primary Language:(circle one) English Spanish Other:________ Ethnicity: (circle one) Hispanic Non-Hispanic Declined

Race: (circle one) African American Non Hispanic Caucasian Asian Declined Other___________

HIPPA –Notice of PRIVACY Practice

The HIPPA Privacy Rule was created to give individuals the right to restrict the release of their medical information and to designate to whom their information may be given. We are required by State and Federal laws, including the HIPPA rules, to safeguard general and health related information about you. We have created a Notice of Privacy Practices that explains how your protected health information is handled. The Notice of Privacy Practices is provided to patients and or their authorized representatives when they first become a patient in our office. By signing, you are acknowledging that you were offered or received a copy of the Notice of Privacy practices.

I acknowledge that CT Kidney and Hypertension Specialists, LLC has offered or provided me a copy of its Notice of Privacy Practices, describing how medical information about me may be used and disclosed, and how I can access this information. I understand that if I have questions or complaints I may contact the officer manager: **Pamela Brandt (203597-9733).** I also understand that I am entitled to receive updates upon request if CT Kidney and Hypertension Specialists, LLC amends or changes its Notice of Privacy Practices in a material way.

_______________________________________ ________________________________
Signature of Patient or Patient's Representative Date

_______________________________________ ________________________________
Printed Name of Patient or Patient's Representative Relationship

MEDICARE AUTHORIZATION - FINANCIAL RESPONSIBILITY POLICY

I request that payment of authorized Medicare benefits be made on my behalf directly to CT Kidney ad Hypertension Specialists for services rendered to me. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim.

CT Kidney and HTN Specialists, LLC participates in a multitude of insurance and health plans to better serve you. With the overwhelming complexity to collect fees from all these plans, we must ask you to take responsibility for understanding your own coverage. We expect co-payments and deductibles to be made at the time of service. The office asks: The patient will be responsible for any or all portions of his or her bill that is not covered by the insurance carrier or if erroneous insurance or health plan information prevents collection of fees from the insurance carrier or health plan. If your insurance requires that you have a referral from your Primary Care provider, it is your responsibility to ensure that our office receives the referral before your visit.

____ ____
Signed Date

____ ____
Witness Date

AMBULATORY BLOOD PRESSURE MONITOR (only) RESPONSIBILITY

By signing below, I am responsible for any damage (s) or loss to the Blood Pressure Monitor while it is in my possession.

Signature _______________________________________ Date____

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ALLERGIES TO MEDICATIONS/ REACTIONS: *(please list)*

PAST MEDICAL HISTORY:

Please check any of the following illness you have or are suffering from:

	ACUTE KIDNEY FAILURE		CONGESTIVE HEART FAILURE		THYROID DISORDER
	ANEMIA		CVA/STROKE		VALVE REPLACEMENT
	ATRIAL FIBRILLATION		DVT/BLOOD CLOT		KIDNEY STONES
	CANCER-______________________		DIABETES MELLITUS		SLEEP APNEA
	CHRONIC KIDNEY DISEASE		HEPATITS		PROTEIN IN URINE
	HEART ATTACK/ANGINA		GOUT		PERIPHERAL VASCULAR DISEASE
	COPD/ EMPHYSEMA		HIGH CHOLESTEROL		SEIZURE DISORDER
	AUTOIMMUNE DISEASE (LUPUS) (SJOGRENS) (RHEUMATOID)		HIGH BLOOD PRESSURE		URINARY TRACT INFECTION

Other *(please list)*

____

SURGERIES: Approximate Date | Operation

Approximate Date	Operation

CURRENT MEDICINES *OR PROVIDE A LIST TO BE COPIED*. CLICK HERE IF: ☐ No **Medications**

MEDICATION	DOSE	How Often?	MEDICATION	DOSE	How Often?
1.			6.		
2.			7.		
3.			8.		
4.			9.		
5.			10.		

FAMILY HISTORY

	Alive	Age	Health Status or Cause of Death	Kidney Disease	High Blood Pressure	Kidney Stones	Diabetes
Mother	Yes/No						
Father	Yes/No						
Brother/Sister	Yes/No						
Brother/Sister	Yes/No						
Children	Yes/No						

Social History

Marital Status: *(circle)* Married Divorced/Separated Widowed Single Engaged

Occupation: ___________________________________ ☐ Retired ☐ Disabled ☐Homemaker
Hobbies:______________________________________ Do you live alone? Yes__ No__

Do you now, or have you ever used Tobacco? NO YES If Yes, Number of years? _______
If you no longer use tobacco, when did you Quit? Date: _______________________
Do you now, or have you ever used Recreational Drugs? NO YES
Do you now, or have you ever used Alcohol? NO YES If Yes, How much per week? ____

Name____________________
DOB__________________

Immunizations Have you been immunized for: *Check all that Apply?*

☐ Pneumovax Date___________
☐ Prevnar 13 Date___________
☐ Influenza Date___________
☐ Hepatitis B Date___________
☐ Shingles/ Zostavax Date___________

Medical History- *Check all that Apply*

General	**Eyes**	**Skin**	**Ears, Nose ,Throat**
□ Fever □ Chills □ Night sweats □Headache	□Change in vision □Dry eyes □Redness eye □Itchy eye	□Rash □Itching □Hives	□Hearing Loss □Nose Bleeds □Sinus Disease □Mouth Ulcers
Kidney □Reduced Urine flow □Blood in Urine □Foam in Urine □Urinary Hesitancy □ Urinary □History of Dialysis	**Urological** □Waking up to urinate □Incontinence □Incomplete Bladder emptying □Kidney Stones □Urinary Tract Infection	**Heart** □Chest pain □Palpitations □Shortness of Breath □Leg Swelling □Pain Legs - exertion	**Lungs** □Cough □Coughing Up Blood □ Coughing up Sputum □Wheeze □Snore at night □Fatigue
Gastrointestinal □Loss Appetite □Nausea □Vomiting □Constipation □Diarrhea □Heartburn	**Endocrine/Pysch** □Low Blood Glucose □Depression □Weight Loss □Weight Gain □Prior Lithium Use □Insomnia	**Muscoloskeletal** □Arthritis □Back Pain □Muscle Pain □Restless Legs □Numbness/ Tingling □Gout □ Leg Cramps	**Hematology** □Anemia □Bleeding Problems □Easy Bruising □History Blood Clot □Swollen Glands

Renal Specific Questions:

Use of NSAIDS?- Advil, Motrin, Aleve, Naprosyn, Celebrex etc No___ Yes___ Duration_______
Use of Proton Pump Inhibitor? –Protonix, Prevacid, Omeprazole No___ Yes___ Duration_______
Use of Recent (< 1month) Contrast/ Dye Exposure? No___ Yes___ Date___________
Have you ever required hemodialysis No___ Yes___ Duration________
Were you born pre-mature (before 38 weeks old)? No___ Yes___ Weeks__________
Did you have a Recent Kidney US? – if yes: when and where________________________________