RENAL CARE HOUSTON

Nephrology New Patient Packet

Personal Information:

- Last Name: _____
- First Name: _____
- Middle Name: _____
- SSN: _____
- Date of Birth: _____
- Gender: M ☐ F ☐
- Marital Status: _____
- Street Address: _____
- City: _____
- State: _____
- Zip: _____
- Home Phone: _____
- Work Phone: _____
- Cell Phone: _____
- Email Address: _____
- Preferred Method of Contact: ☐ Home Phone ☐ Work Phone ☐ Cell Phone

Demographics:

- Primary Language: _____
- Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino
- Race: ☐ Black or African American ☐ Asian ☐ Native Hawaiian or Pacific Islander ☐ American Indian or Alaska Native ☐ White ☐ Other

Emergency Contact:

- Name: _____
- Phone: _____
- Relationship: _____

Insurance Information:

- Primary Insurance Company: _____
- ID/Policy #: _____
- Group #: _____
- Insurance Phone: _____
- Is this policy through your employer? **YES** ☐ **NO** ☐
- Spouse's employer? **YES** ☐ **NO** ☐
- Secondary Insurance Company: _____
- ID/Policy #: _____
- Group #: _____
- Insurance Phone: _____
- Is this policy through your employer? **YES** ☐ **NO** ☐
- Spouse's employer? **YES** ☐ **NO** ☐

Kidney Doctor Information:

- Are you currently under the care of another kidney doctor OR have you been seen by a kidney doctor within the last 10 years? (Please choose one) **YES** ☐ **NO** ☐
- If yes: Doctor's Name: _____ Date Last Seen: _____

Signature:

Patient's Signature: _____ Date: _____

YOUR MEDICAL HISTORY

Acute Kidney Disease:	**YES ☐**	**NO ☐**
Anemia:	**YES ☐**	**NO ☐**
Anxiety:	**YES ☐**	**NO ☐**
Arthritis:	**YES ☐**	**NO ☐**
Asthma:	**YES ☐**	**NO ☐**
Autoimmune Disease:	**YES ☐**	**NO ☐**
Bleeding problems:	**YES ☐**	**NO ☐**
Cancer:	**YES ☐**	**NO ☐**
CKD- Chronic Kidney Disease:	**YES ☐**	**NO ☐**
Congestive Heart Failure:	**YES ☐**	**NO ☐**
Coronary Artery Disease:	**YES ☐**	**NO ☐**
Depression:	**YES ☐**	**NO ☐**
Diabetes:	**YES ☐**	**NO ☐**
DVT (Deep Venous Thrombosis):	**YES ☐**	**NO ☐**
Eye disease:	**YES ☐**	**NO ☐**
Frequent colds:	**YES ☐**	**NO ☐**
GI Disorders:	**YES ☐**	**NO ☐**
Gout:	**YES ☐**	**NO ☐**
Hearing problems:	**YES ☐**	**NO ☐**
Hepatitis:	**YES ☐**	**NO ☐**
High blood pressure:	**YES ☐**	**NO ☐**
Hyperlipidemia (High Cholesterol):	**YES ☐**	**NO ☐**
MI (Heart attack):	**YES ☐**	**NO ☐**
Nephrolithiasis (kidney stones):	**YES ☐**	**NO ☐**
Neuromuscular disease:	**YES ☐**	**NO ☐**
Neuropathy (disease of nerves):	**YES ☐**	**NO ☐**
Protein in Urine:	**YES ☐**	**NO ☐**
Retinopathy (Retina disease):	**YES ☐**	**NO ☐**
Sleep apnea:	**YES ☐**	**NO ☐**
Stroke:	**YES ☐**	**NO ☐**
Thyroid:	**YES ☐**	**NO ☐**
UTI (Urinary tract infections):	**YES ☐**	**NO ☐**

Other: Please Explain _____

PAST SURGICAL HISTORY	**YEAR**

PERSONAL & SOCIAL HISTORY

- Born (place of birth): _____
- Marital Status: _____
- Occupation: _____
- Live alone: **YES** ☐ **NO** ☐
- If no, who lives with you? _____
- Do you have children: **YES** ☐ **NO** ☐
    - If so, how many? Sons: _____ Daughters: _____
- **Habits:**
    - Diet: _____
    - Exercise: **YES** ☐ **NO** ☐
    - Alcohol: **YES** ☐ **NO** ☐
        - If yes, how much: _____
    - Smoke: Yes / No
        - If yes, how long: _____
    - Have you ever smoked: **YES** ☐ **NO** ☐
        - Quit, when: _____
- Transfusions: **YES** ☐ **NO** ☐
    - Date: _____
- Drug use: **YES** ☐ **NO** ☐
    - Explain: _____

YOUR FAMILY MEDICAL HISTORY

- Anemia: **YES** ☐ **NO** ☐ **Relation** _____
- Autoimmune disease: **YES** ☐ **NO** ☐ **Relation** _____
- Cancer: **YES** ☐ **NO** ☐ **Relation** _____
- Coronary artery disease: **YES** ☐ **NO** ☐ **Relation** _____
- Diabetes Mellitus: **YES** ☐ **NO** ☐ **Relation** _____
- Hyperlipidemia (High Cholesterol): **YES** ☐ **NO** ☐ **Relation** _____
- Hypertension: **YES** ☐ **NO** ☐ **Relation** _____
- Kidney disease: **YES** ☐ **NO** ☐ **Relation** _____
- Kidney stones: **YES** ☐ **NO** ☐ **Relation** _____
- Strokes: **YES** ☐ **NO** ☐ **Relation** _____
- Other medical history - please explain: _____

MEDICATION LIST

****Please list ALL medications, dosage, and instructions. This includes over the counter medications.****

Name: _____ Date of Birth: _____

Pharmacy: _____

Pharmacy Zip Code: _____

Allergies: _____

Medication	Dosage	Direction

CURRENT SYMPTOMS:

- Do you currently have any of the following symptoms? (Check all that apply)
    - ☐ Fatigue
    - ☐ Swelling in legs/feet
    - ☐ Shortness of breath
    - ☐ Nausea/Vomiting
    - ☐ Loss of appetite
    - ☐ Frequent urination
    - ☐ Pain in the kidney area
    - ☐ Blood in urine
    - ☐ Other (please specify): _____

RECENT TESTS & PROCEDURES:

- Have you had any of the following tests or procedures recently? (Check all that apply and provide dates if possible)
    - ☐ Blood test: Date: _____
    - ☐ Urine test: Date: _____
    - ☐ Ultrasound: Date: _____
    - ☐ CT scan: Date: _____
    - ☐ MRI: Date: _____
    - ☐ Biopsy: Date: _____
    - ☐ Dialysis: Date: _____
    - ☐ Other (please specify): _____

ALLERGIES:

- Do you have any allergies to medications, foods, or other substances? YES ☐ NO ☐
    - If yes, please list: _____

REFERRAL INFORMATION:

- How did you hear about our practice?
    - ☐ Physician referral: Name: _____
    - ☐ Friend/Family
    - ☐ Internet search
    - ☐ Insurance company
    - ☐ Other (please specify): _____

CONSENT OF TREATMENT:

I hereby give my consent for Renal Care Houston to provide medical care and treatment to me.

Patient's Signature: _____ Date: _____

ASSIGNMENT OF BENEFITS

Your signature is necessary for us to process any insurance claims and to ensure payment of services rendered.

I request that payment of authorized insurance benefits, including Medicare if I am a Medicare beneficiary, be made on my behalf to Renal Care Houston for any equipment or services provided to me by its physicians or clinical staff. I authorize the release of any medical or other information necessary to determine these benefits or the benefits payable for related equipment or services to Renal Care Houston , my insurance carrier, or other medical entity. A copy of this authorization will be sent to my insurance company or other entity if requested. The original authorization will be kept on file by Renal Care Houston. I understand that I am financially responsible to the organization for any charges not covered by health care benefits. It is my responsibility to notify the organization of any changes in my health care coverage. In some cases exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by the organization and/or my health care insurer if the submitted claims or any part of them are denied for payment. I understand that by signing this form I am accepting financial responsibility as explained above for all payment for services rendered. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and I understand the information above. I agree to be financially responsible for all charges as discussed above.

Patient Signature: _____

Date: _____

Witness: _____

Responsible Party: _____

Patient Contact Record

Patient's Name: _____

Date: _____

The HIPAA Privacy Rule gives individuals the right to restrict release of their Private Health Information (PHI). Please list the individual(s) you will allow Nephrology Associates, P.A. to release or discuss your PHI with. Do not list other physicians.

1. _____
2. _____
3. _____
4. _____
5. _____

Signature _____ Date _____

RECEIPT NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT OF FORM I, _____ have received a copy of Renal Care Houston notice of privacy Practices.

Print Patient's Name: _____

Patient Signature: _____

Date: _____