



NAME:	DATE OF BIRTH:
SOCIAL SECURITY #:	SEX: MALE / FEMALE / _____
MAILING ADDRESS:	
STREET ADDRESS: (IF DIFFERENT)	
PREFERRED PHONE NUMBER:	Ok to leave voice mails: <input type="checkbox"/> Yes <input type="checkbox"/> No
ALTERNATE PHONE NUMBER:	
EMAIL:	
RACE: AFRICIAN AMERICAN _____ CAUCASIAN _____ HISPANIC _____ ASIAN _____ AMERICAN INDIAN _____ OTHER: _____	
SINGLE _____ MARRIED _____ WIDOW _____ SEPERATED _____ DIVORCED _____	
Pharmacy: _____	

EMERGENCY CONTACT:	PHONE NUMBER:

Release of Medical Information: By signing below, I authorize Nephrology Associates of the Carolina's PA to release my medical and billing information, and leave a message if needed, to the following, including my emergency contact.

Initial: _____

RELEASE OF INFORMATION: NAME	PHONE NUMBER:

Insurance: Please have your cards out for us to make a copy of. By signing below, I understand that I am responsible for any payment due. It is my responsibility to provide current correct insurance information, in a timely manner.

Initial:

PRIMARY INSURANCE:	
SECONDARY INSURANCE:	
TERTIARY INSURANCE:	
DO YOU HAVE AN ADVANCED DIRECTIVE?	Yes _____ NO _____
(Please circle which directive you have)	No Advanced Directive
Do Not Resuscitate	Do Not Intubate
Living Will	Power of Attorney
Surrogate Decision Maker _____	Organ Donor

Signature: _____

Date: _____



Name: _____

DOB: _____

Consent to Treat and Insurance Assignment and Release:

I authorize Nephrology Associates of the Carolinas, PA to render necessary treatment to me. I hereby authorize the release of medical information including complete medical records, test results, and billing information to my insurance company, other medical professionals, and medical institutions that I may be referred to for treatment. This authorization also includes prescription history. I understand this information will be used to review, investigate, make payment of claim, and to review records for complaint resolution. I authorize payment directly to Nephrology Associates of Carolina's, PA for all medical benefits otherwise payable to me under the terms of my health insurance. I understand that I am financially responsible for all copayments, coinsurances, deductibles, and any other non-covered services. A photocopy of this authorization shall be considered as effective and as valid as the original.

Initial: _____

Patient Provider Contract: The goal of our staff and physicians is providing kind, courteous, and excellent medical care. Our intent is to help patients understand their medical situation and work with them to maximize health and minimize the effects of illness. We will provide an environment where learning and healing can occur, where you do not feel afraid or embarrassed to ask a question. We appreciate the opportunity to work with you to solve any problems you may have and encourage you, and your family, to let us know if you are dissatisfied. However, we cannot and will not tolerate abusive or threatening language or behavior, under any circumstances. I understand that this would be cause for immediate dismissal from our practice.

Initial: _____

Notice of Privacy Practices Acknowledgement: By signing below, I acknowledge that the *Notice of Privacy Practices of Nephrology Associates of Carolina's, PA*, is available to me, at any time. Our *Notice of Privacy Practices* provides information about how we may use and disclose your protected health information. We encourage you to review it carefully. Our *Notice of Privacy Practices* is subject to change. If we change our notice, you may obtain a copy of the revised one by requesting one from one of our health care team members.

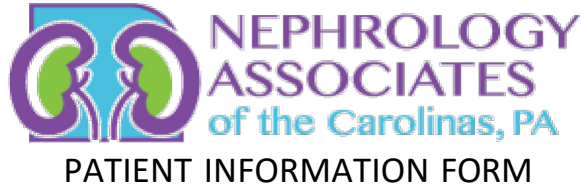
Initial: _____

Consent to Obtain External Pharmacy History: I understand that the prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be accessed by my provider and Nephrology Associates staff. This may include prescriptions dating back several years. My signature certifies that I read and understood the scope of my consent and that I authorize the access.

Initial: _____

Signature: _____

Date: _____



Patient Medical History Form

Patient Name: _____ Date of Birth: _____

Medical History: Have you ever been treated for any of the following medical conditions?

- | | | |
|--|---|--|
| <input type="checkbox"/> No changes | <input type="checkbox"/> Cancer | Please list any additional medical conditions:
_____ |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Depression/anxiety | |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart problems | Have you ever been hospitalized overnight? <input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever had surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> High cholesterol | |
| <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Lung problems | _____ |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Thyroid problems | _____ |

Medications and Allergies: will be reviewed by clinic staff.

(Please bring your bottles with you or a complete list of everything you take on a regular basis.)

If you bring a list, make sure to list the strength and how you are taking the medication.

Do you take any supplements (calcium/vitamin D/fish oil/multivitamin)? Yes No

Social History:

Are you retired? Yes No Are you disabled? Yes No

Work Type: _____

Tobacco (chew/smoke): _____ per day

Alcohol (beer/wine, etc.): _____ per day

Drugs (marijuana, etc.): _____

Caffeine (coffee/tea/soda): _____ per day

Blood Transfusion? Yes No if yes date: _____

Status: Married Single Widowed Divorced/Separated

REVIEW OF SYSTEMS

Please circle any current symptoms below:

Constitutional:

Fatigue

Fever

Cardiovascular:

Chest Pain

Edema

Leg swelling

Heart palpitations

Neurological:

Dizziness

Focal weakness

Headache

HEENT:

Hearing loss

Visual loss

Gastrointestinal:

Abdominal pain

Diarrhea

Nausea

Vomiting

Psychiatric:

Depression

Anxiety

Respiratory:

Cough

Shortness of breath

Genitourinary:

Painful urination

Blood in urine

Urinary frequency

Urinary incontinence

Integumentary:

Itching

Rash

Skin Ulcers

Have you ever had any of the following:

Kidney Ultrasound: Yes No Date: _____ Where: _____

Renal Artery Doppler: Yes No Date: _____ Where: _____

Kidney Biopsy: Yes No Date: _____ Where: _____

24 Hr Urine Collection: Yes No Date: _____ Where: _____

Echocardiogram: Yes No Date: _____ Where: _____

Have you ever had a transplant? Yes No Date: _____

Where: _____ Type: _____

Family Medical History

Has anyone in your family had any of the following:

Kidney disease: Yes___ No___ If yes, list family member(s): _____

Protein in urine: Yes___ No___ If yes, list family member(s): _____

Blood in urine: Yes___ No___ If yes, list family member(s): _____

Dialysis: Yes___ No___ If yes, list family member(s): _____

Diabetes Type 1: Yes___ No___ If yes, list family member(s): _____

Diabetes Type 2: Yes___ No___ If yes, list family member(s): _____

Hypertension: Yes___ No___ If yes, list family member(s): _____

Auto Immune: Yes___ No___ If yes, list family member(s): _____

Kidney Stones: Yes___ No___ If yes, list family member(s): _____

Polycystic Kidney Disease: Yes___ No___ If yes, list family member(s): _____

Cancer: Yes___ No___ If yes, list family member(s): _____

Other: Yes___ No___ If yes, list family member(s): _____

Signature: _____ Date: _____