MIDWEST NEPHROLOGY CONSULTANTS, P.A. PATIENT REGISTRATION

Patient Biographical Information (Leave no section blank-If not applicable, write N/A)

Name: Last: _____ **First:** _____ **Middle Int:** _____

Date of Birth: _____ **Social Security Number:** _____ **☐ Male/☐ Female**

Phone: Home: _____ **Cell:** _____ **Work:** _____

Address: _____
City State Zip

Email Address: _____

Primary Physician: _____ **Referring Physician:** _____

Required by Federal Law	
Race Check one ☐ 1- Asian ☐ 2- Black African American ☐ 3- White ☐ 5- American Indian/ Alaskan Native ☐ 10- Pacific Islander ☐ 11- More than one race ☐ 12- Native Hawaiian ☐ 13- Refused to report ☐ 14- Undefined	Marital Status ☐ 1-Single ☐ 4- Widowed ☐ 2-Married ☐ 5- Divorced ☐ 3-Unknown ☐ 6- Separated
Ethnicity ☐ Hispanic or Latino ☐ Non-Hispanic or Latino ☐ Refused to report or Unreported ☐ Undefined	Language ☐ English ☐ Spanish ☐ Other_____

Emergency Contact Information:

Name: _____ Relationship: _____

Phone Number: _____ Cell: _____

Will you allow us to leave pertinent information with this person? Yes / No ☐ ☐

Primary Insurance Information:

Insurance Company Name: _____

Policy Number: _____ Group Number: _____

***Policy Holder / Subscriber*:** _____ Date of Birth: _____

Relationship to Subscriber ☐Self ☐ Husband ☐ Wife ☐ Son ☐ Daughter ☐ Other

SSN _____

Employer Name _____ Employed: Yes / No / Retired

Employer Number: _____ ☐ ☐ ☐

Secondary Insurance Information:

Insurance Company Name: _____

Policy Number: _____ Group Number: _____

Policy Holder / Subscriber: _____ Date of Birth: _____

Relationship to Subscriber ☐Self ☐ Husband ☐ Wife ☐ Son ☐ Daughter ☐ Other

SSN _____

Employer Name _____ Employed: Yes / No / Retired

Employer Number: _____ ☐ ☐ ☐

Date: _____ Account #: _____

HEALTH QUESTIONNAIRE

Dear Patient: Today's Date: _____

Please **print** and **complete** all information where applicable. The information on this form will help your Doctor provide you with better medical care. *All information will be treated as confidential unless you grant permission to release it.*

Patient Name: _____ Age: _____

Address: _____ City: _____

Phone No: ( ) _____ State/Zip: _____

PAST MEDICAL HISTORY:

Surgical Operations & Year Performed:

Medical Illnesses & Year of Illness:

Allergies:

Injuries & Year of Injury:

FAMILY HISTORY CONT.:

	If Living		If Deceased	
	Age	*Health*	*Age*	*Cause*
Father				
Mother				
Brothers				
Sisters				

SOCIAL HISTORY:

Occupation: _____

Marital Status: _____

Number of Children: _____

Do You Drink Alcohol? _____

How Much? _____

Do You Smoke? _____

How Much?/How Long? _____

FAMILY MEDICAL HISTORY:

Have Any *Blood Relatives* Ever Had the Following?

Please Circle:	Who?:	Please Circle:	Who?:
Anemia		High Blood Press	
Arthritis		Kidney Disorder	
Cancer		Lung Disease	
Diabetes		Mental Illness	
Epilepsy		Migrane	
Goiter		Stomach Ulcers	
Heart Trouble		Stroke	
		Tuberculosis	

TB ASSESSMENT:

Persistent Cough/Coughing Blood?	Yes/No/Not Sure
Unexplained Night Sweats, Wt Loss, Loss of Appetite or Fevers?	Yes/No/Not Sure
Have you been exposed to friends/family with TB?	Yes/No/Not Sure
Are you Foreign Born or Lived Abroad?	Yes/No/Not Sure

List All Medications You are Now Taking:

	Med Name	Dosage	time's daily
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			
15.3			

03/11

INITIALLY REVIEWED BY DR. _____ ***Date:*** _____

Midwest Nephrology Consultants, PA

Authorization & Assignment

Please read carefully

I hereby authorize Midwest Nephrology Consultants, P.A. and physicians to furnish to/or receive from CMS and its agents, insurance companies, and other health care providers any and all information concerning my medical or physical condition, diagnosis, or treatment.

I hereby assign payment of medical/surgical benefits to Midwest Nephrology Consultants, P.A. for medical/surgical services rendered to me or my dependents.

I understand that I am financially responsible for all services rendered which are not covered by my insurance.

I also understand that if I elect to visit a specialist and receive specialty services without a valid referral when one is required by my insurance, then I am solely responsible for payment of services rendered. I understand that I am responsible for furnishing valid referrals from my primary care physician.

Signature: _____ Date: _____

Disclosure of, Presentation, & Scanning of Driver's License or State ID

Please read carefully

In order to help prevent fraudulent use of your insurance card, Midwest Nephrology Consultants, P.A., requests permission to view, scan and copy your driver's license or State ID.

You have the right to refuse having your driver's license scanned or copied.

At each visit please have your driver's license or State ID available for verification or identity.

By signing below, you agree to and understand the information that is stated above.

Signature: _____ Date: _____

All information provided is confidential and will only be used to process treatments, payments, and necessary operations of the medical practice and will be released only under strict HIPAA (Health Insurance Portability and Accountability Act) compliance guidelines.

Prohibition of Video Recording During Office Visits

Please read carefully

We value your privacy. For your protection and possible unauthorized dissemination and interpretations, we ask that you do not video record your visit.

Thank you.

Signature: _____ Date: _____

Social Security Numbers

Please read carefully

We value your privacy. The Insurance industry has changed considerably and most times – the inclusion of a patient's social security number is no longer required. However, there are still some carriers that will require this for identification of a patient. We understand if you do not wish to provide this sensitive number. If it should be required, we will contact you directly.

Thank you.

Signature: _____ Date: _____

Date: _____

Account#: _____

NEW PATIENT- REVIEW OF SYSTEMS

CHECK ALL THAT APPLY TO YOU

GENERAL:

- ☐ FEVER
- ☐ NIGHTSWEATS
- ☐ WEAKNESS
- ☐ FATIGUE
- ☐ RECENT WEIGHT CHANGES (DECREASED)
- ☐ RECENT WEIGHT CHANGES (INCREASED)

SKIN:

- ☐ RASH
- ☐ ITCHING
- ☐ CHANGE IN HAIR
- ☐ CHANGE IN NAILS
- ☐ VARICOSE VEINS
- ☐ CHANGE IN SKIN COLOR
- ☐ THINNING HAIR
- ☐ BREAST PAIN
- ☐ NIPPLE DISCHARGE

CARDIOVASCULAR:

- ☐ CHEST PAIN
- ☐ PALPITATIONS
- ☐ SWELLING OF HANDS
- ☐ SWELLING OF ANKLES
- ☐ HEART TROUBLE
- ☐ PAIN IN CALVES WHEN WALKING

GASTROINTESTINAL:

- ☐ NAUSEA
- ☐ VOMITTING
- ☐ BLOOD IN STOOL
- ☐ CONSTIPATION
- ☐ FREQUENT DIARRHEA
- ☐ LOSS OF APPETITE
- ☐ CHANGE IN BOWEL HABITS
- ☐ DO YOU/HAVE YOU EVER HAD HEPATITIS
- ☐ ULCER
- ☐ PAINFUL BOWEL MOVEMENTS
- ☐ ABDOMINAL PAIN

NAME:

_____

DOB:

_____

ENDOCRINE:

- ☐ DIABETIC
- ☐ THYROID DISEASE
- ☐ EXCESSIVE THIRST
- ☐ EXCESSIVE URINATION
- ☐ HEAT INTOLERANCE
- ☐ COLD INTOLERANCE
- ☐ HORMONE PROBLEM

PSYCHIATRIC:

- ☐ MEMORY LOSS
- ☐ CONFUSION
- ☐ NERVOUSNESS
- ☐ DEPRESSION
- ☐ DIFFICULTY SLEEPING

RESPIRATORY:

- ☐ FREQUENT COUGH
- ☐ SHORTNESS OF BREATH
- ☐ SNORING
- ☐ SLEEP APNEA

  If yes do you use a CPAP?_____
- ☐ SPITTING UP BLOOD
- ☐ WHEEZING
- ☐ ASTHMA
- ☐ OXYGEN USE

MUSCULOSKELETAL:

- ☐ JOINT PAIN
- ☐ JOINT SWELLING
- ☐ WEAKNESS IN MUSCLES
- ☐ MUSCLE CRAMPS
- ☐ MUSCLE PAIN
- ☐ BACK PAIN
- ☐ DIFFICULTY WALKING
- ☐ NSAID USE

NEUROLOGICAL:

- ☐ NUMBNESS
- ☐ TINGLING
- ☐ FREQUENT HEADACHES
- ☐ LIGHTHEADED
- ☐ DIZZINESS
- ☐ CONVULSIONS
- ☐ TREMBLING
- ☐ PARALYSIS
- ☐ SEIZURES
- ☐ STROKE
- ☐ HEAD INJURY

NEW PATIENTS - REVIEW OF SYSTEMS

CHECK ALL THAT APPLY TO YOU

GENITOURINARY:

- ☐ URINARY INCONTINENCE
- ☐ FREQUENT URINATION
- ☐ BURNING/PAINFUL URINATION
- ☐ AWAKEN AT NIGHT TO URINATE
- ☐ CHANGE IN URINE STREAM FORCE
- ☐ BLOOD IN URINE
- ☐ DRIBBLING
- ☐ KIDNEY STONES
- ☐ SEXUAL DIFFICULTY

MALES ONLY:

- ☐ TESTICLE LUMPS
- ☐ TESTICLE PAIN

FEMALE ONLY:

- ☐ PAINFUL PERIODS
- ☐ IRREGULAR PERIODS
- ☐ VAGINAL DISCHARGE

Date of last mammogram?_____

Date of last pap smear?_____

Number of pregnancies? _____

Number of miscarriages?_____

Health maintenance

- ☐ PNEUMONIA VACCINE

if yes, date: _____

- ☐ INFLUENZA VACCINE

if yes, date last given: _____

HEMATOLOGY:

- ☐ ANEMIA
- ☐ BLEEDING TENDENCY
- ☐ BRUISING TENDENCY
- ☐ BLOOD CLOT
- ☐ TRANSFUSIONS
- ☐ SLOW TO HEAL AFTER CUTS
- ☐ CANCER

If yes what type? _____

EYES:

- ☐ WEAR GLASSES
- ☐ WEAR CONTACT LENSES
- ☐ BLURRED VISION
- ☐ DOUBLE VISION
- ☐ GLAUCOMA
- ☐ CATARACTS
- ☐ EYE DISEASE

NOSE/THROAT:

- ☐ HEARING LOSS
- ☐ RINGING IN THE EARS
- ☐ EARACHES
- ☐ EAR DRAINAGE
- ☐ CHRONIC SINUS PROBLEMS
- ☐ NOSE BLEEDS
- ☐ MOUTH SORES
- ☐ SORE THROAT
- ☐ HOARSENESS
- ☐ SWOLLEN GLANDS IN NECK

NAME:

_____

DOB:

_____

MIDWEST NEPHROLOGY CONSULTANTS, P.A. PRIVACY NOTICE
PATIENT ACKNOWLEDGEMENT/ TELEPHONE CONTACT

I, _____ have received a copy of Midwest Nephrology Consultants Privacy Policy.

_____ _____
Patient / Guardian or Representative Signature Date

The primary contact phone numbers for our authorized staff to leave confidential, detailed medical messages in order to manage your specific medical condition while under the care of Midwest Nephrology Consultant physicians are:

_____ _____.
Primary telephone number Secondary telephone number

Additionally, I understand and agree to disable any call blocking feature from the above listed telephone numbers.

I, _____ give consent to Midwest Nephrology for the next 365 days, (unless revoked by me sooner) to ***disclose or discuss detailed medical information and/or billing information*** with the following person or persons. **Please mark all that apply:**

☐ Spouse: _____ ☐ Father: _____

☐ Mother: _____ ☐ Daughter: _____

☐ Son: _____ ☐ Sister: _____

☐ Brother: _____

☐ Power of Attorney: _____
Document must be on file.

☐ Legal Guardian: _____
Document must be on file.

☐ Executor and/or Trustee: _____
Document must be on file.

☐ Other: _____
Document must be on file and/or approved by the Administrator and/or the Nursing Coordinator.

_____ (Initial) I understand this is time specific, and in order for information to be released a current HIPAA notice must be on file.

**********Subsequent visits: do not complete unless requested**********

1._____ (Initial) I have checked all information and requested no changes be made at the time. Please extend this request for an additional 365 days. This will end _____ (date) unless revoked by me sooner.

2._____ (Initial) I have checked all information and requested no changes be made at the time. Please extend this request for an additional 365 days. This will end _____ (date) unless revoked by me sooner.

After the above date has expired or is revoked by me, I am aware a new HIPAA request must be filled out.

****