

METRO NEPHROLOGY
NEW PATIENT REGISTRATION FORM

First Name: _____ Last Name: _____ MI _____

DOB _____

Address: _____ apt# _____

City: _____ State: _____ Zip: _____

Ph: Home _____ Work _____ Cell _____

Gender: Male Female Other

Marital Status: Married Single Divorced Widowed

Spouse's name, if married _____

Discuss medical condition with a family member? Yes No

If yes, whom _____ Relation _____

Emergency contact, not living with you _____

Phone: _____ Relation _____

Employer _____

(If not currently employed, please list spouse or parent's Employer)

Employer Address _____

GENERAL MEDICAL INFORMATION

Describe the current medical problem/reason for today's visit:

Female: Are you pregnant Planning a pregnancy Nursing a child

Primary Care Physician (PCP): _____

Referring Physician, if not PCP: _____

Other physicians currently treating you: _____

Medical History - Please *check* if you have/had any of the following:

<input type="checkbox"/> Acute kidney failure <input type="checkbox"/> Frequent urinary infections <input type="checkbox"/> Rheumatoid arthritis <input type="checkbox"/> Cirrhosis <input type="checkbox"/> Chronic kidney disease <input type="checkbox"/> Prostate enlargement <input type="checkbox"/> Depression <input type="checkbox"/> End stage renal disease/Dialysis <input type="checkbox"/> Coronary artery disease <input type="checkbox"/> Anemia Diabetes Type 1 Type 2 <input type="checkbox"/> Congestive heart failure <input type="checkbox"/> Hepatitis <input type="checkbox"/> Lupus	<input type="checkbox"/> Dementia <input type="checkbox"/> Polycystic kidney disease <input type="checkbox"/> COPD <input type="checkbox"/> Stroke <input type="checkbox"/> Parkinson's disease <input type="checkbox"/> Kidney stones <input type="checkbox"/> Arthritis <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Adrenal insufficiency <input type="checkbox"/> Atrial fibrillation <input type="checkbox"/> Ulcerative Colitis <input type="checkbox"/> Hypertension <input type="checkbox"/> Hypothyroidism <input type="checkbox"/> Crohn's disease
Other	

Hospitalizations: Please list any previous hospitalizations and dates: NONE

Month/Year	Reason for hospitalization	Name of the hospital

Surgical History: Please list any previous surgeries and dates NONE

<input type="checkbox"/> Heart bypass surgery <input type="checkbox"/> Kidney stone removal <input type="checkbox"/> Hip replacement <input type="checkbox"/> Heart valve surgery <input type="checkbox"/> Kidney removal <input type="checkbox"/> Knee replacement <input type="checkbox"/> AV fistula/graft surgery	<input type="checkbox"/> Bowel resection <input type="checkbox"/> Prostate surgery <input type="checkbox"/> Pacemaker/defibrillator placement <input type="checkbox"/> Amputation of _____ <input type="checkbox"/> Transplantation of _____ <input type="checkbox"/> Coronary artery stent placement
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Other surgeries not mentioned above:

Family History:

Disease	Father	Mother	Sibling	Other family members
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Chronic kidney disease	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
End stage renal disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

<p>Smoking Status:</p> <input type="checkbox"/> Current smoker, ___ cigarettes a day <input type="checkbox"/> Never smoked <input type="checkbox"/> Former smoker, quit _____ years ago <input type="checkbox"/> Unknown	<p>Alcohol consumption:</p> <input type="checkbox"/> Frequent, how many drinks a week? _____ <input type="checkbox"/> Occasional <input type="checkbox"/> Former <input type="checkbox"/> Never
<p>Are you a I.V drug user?</p> <input type="checkbox"/> Never <input type="checkbox"/> Current <input type="checkbox"/> Former	<p>If YES, what drug? How often?</p>

Please check symptoms relevant to you.

<p>Constitutional</p> <input type="checkbox"/> Appetite change <input type="checkbox"/> Fatigue <input type="checkbox"/> Weight change	<p>Eyes</p> <input type="checkbox"/> Eye pain <input type="checkbox"/> Visual disturbance	<p>Endocrine</p> <input type="checkbox"/> Cold intolerance <input type="checkbox"/> Excess fluid consumption <input type="checkbox"/> Excess urination	<p>Allergy/Immuno</p> <input type="checkbox"/> Immunocompromised <input type="checkbox"/> Environmental Allergies
<p>ENT</p> <input type="checkbox"/> Hearing loss <input type="checkbox"/> Sinus pain <input type="checkbox"/> Trouble swallowing <input type="checkbox"/> Tinnitus	<p>Respiratory</p> <input type="checkbox"/> Sleep apnea <input type="checkbox"/> Chest tightness <input type="checkbox"/> Cough <input type="checkbox"/> Shortness of breath	<p>Genitourinary</p> <input type="checkbox"/> Difficulty urinating <input type="checkbox"/> Pain during urination <input type="checkbox"/> Night-time urination <input type="checkbox"/> Flank pain <input type="checkbox"/> Frequency of urination <input type="checkbox"/> Blood in urine <input type="checkbox"/> Urgency of urination <input type="checkbox"/> Decreased urine volume	<p>Neurological</p> <input type="checkbox"/> Dizziness <input type="checkbox"/> Light-headedness <input type="checkbox"/> Seizures <input type="checkbox"/> Fainting <input type="checkbox"/> Weakness
<p>Skin</p> <input type="checkbox"/> Rash	<p>Cardio</p> <input type="checkbox"/> Chest pain <input type="checkbox"/> Leg swelling <input type="checkbox"/> Palpitations	<p>Muscle/Joint</p> <input type="checkbox"/> Joint pains <input type="checkbox"/> Back pain <input type="checkbox"/> Gait problem <input type="checkbox"/> Joint swelling <input type="checkbox"/> Muscle pain	<p>Hematologic</p> <input type="checkbox"/> Bruises/Easy bleeding
	<p>Gastrointestinal</p> <input type="checkbox"/> Abdominal pain <input type="checkbox"/> Blood in stool <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting		<p>Psychiatric</p> <input type="checkbox"/> Confusion <input type="checkbox"/> Sleep disturbance

Allergy & Medication History: **No Allergies**

Medication allergy	Reaction(s)

List current medications, (over-the-counter medication, vitamins, and herbal supplements)

Name of Medication(s)	Dosage	Frequency
Pharmacy Name	Phone	
Pharmacy Address		

***Please allow 3 business days for processing prescription refills.**

HIPAA Privacy Authorization Form

1. I authorize _____ (Healthcare provider) to disclose the protected health information described below to **Metro Nephrology**.
2. Effective Period
This authorization for release of information covers the period of healthcare from:
 - a. _____ to _____.
OR
 - b. all past, present, and future periods.
3. Extent of Authorization
 - a. I authorize the release of my complete health record (Including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).
OR
 - b. I authorize the release of my complete health record with the exception of the following information:
 - Mental health records
 - Communicable diseases (including HIV and AIDS)
 - Alcohol/drug abuse treatment
 - Other (Please specify): _____
4. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.
5. This authorization shall be in force and effect until _____ (date or event), at which time this authorization expires.
6. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.
7. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.
8. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Signature of patient or representative:

Date:

Name of patient or representative and his or her relationship to patient:

INSURANCE INFORMATION:

Note: Please enter insurance information below or provide your insurance card at check-in

Primary Insurance (If other than yourself)	Policy Holder Name:	DOB:
	Relationship to Patient:	
Secondary Insurance (If other than yourself)		
	Policy Holder Name:	
	Relationship to Patient:	

Specialist office visit Co-pay: \$ _____

I hereby authorize you to release any information including the diagnosis and the records of any treatment or examination to my insurance company as needed to issue benefits. I understand that my insurance carrier may pay less than the actual bill for services. I understand that my insurer may consider my diagnosis or treatment not medically necessary, and I accept responsibility for all such not covered charges. The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Appointment Policy

Your appointment will be confirmed within 2-3 days of your scheduled time. If for any reason, you cannot make your appointment, we ask that you call at least 24 hours prior to your scheduled appointment. Please plan to arrive 20 minutes prior to your appointment to allow for traffic delays or any additional paperwork. Not following these procedures may delay your visit and you may be asked to reschedule your appointment.

As a courtesy, we will file your claims with the insurance company, but we ask that you come prepared to pay any co-pay or deductible due at the time of your visit. Upon receipt from your insurance company any remaining balance is due in full within 30 days. If you are unable to pay your bill, please discuss alternative arrangements with our billing company. For your convenience our office accepts Visa/Master card/Discover/American Express credit and debit card payments. There is a \$25.00 overdraft fee for any returned checks.

Thank you for choosing our practice and we look forward to seeing you. If you have any questions, please do not hesitate to contact us as **770-663-8766**.

I have read and fully understand the above information and my financial responsibility with Metro Nephrology, Inc.

Patient or Guardian's Signature

Date:

Name:

Relation: