METRO NEPHROLOGY

NEW PATIENT REGISTRATION FORM

First Name:________________________**Last Name:** ______________________ MI _____

DOB _____________ **Email:** _____________________________________

Address: ____ **Apt#** ________

City: ____________________ **State**: _____________ **Zip:** ___________________

Phone: **Home:** __________________________ **Cell:** __________________________

Gender: Male Female Other

Marital Status: Single Married Separated Divorced

If Married, Spouse Name:____________________ Phone: _________________________

Discuss medical condition with : Name: ___________________________________

Relation: _______________________ Phone: ___________________________________

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:

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

☐ Heart bypass surgery	☐ Bowel resection
☐ Kidney stone removal	☐ Prostate surgery
☐ Hip replacement	☐ Pacemaker/defibrillator placement
☐ Heart valve surgery	☐ Amputation of _______________
☐ Kidney removal	☐ Transplantation of _______________
☐ Knee replacement	☐ Coronary artery stent placement
☐AV fistula/graft surgery	

Other surgeries not mentioned above:

_____________________________________ ____________________________________

Family History:

Disease	Father	Mother	Sibling	Other family members
Diabetes	☐	☐	☐	☐
High Blood Pressure	☐	☐		☐
Chronic kidney disease	☐	☐		☐
ESRD	☐	☐	☐	☐

Smoking Status: ☐ Current smoker, ____cigarettes a day ☐ Never smoked ☐ Former smoker, quit _______ years ago ☐ Unknown	**Alcohol consumption**: ☐ Frequent, how many drinks a week? ______ ☐ Occasional ☐ Former ☐ Never
Are you a I.V drug user? ☐ **Never** ☐ **Current** ☐ **Former**	If YES, what drug? How often?

Please check symptoms relevant to you.

Constitutional
☐Appetite change
☐Fatigue
☐Weight change

ENT
☐Hearing loss
☐Sinus pain
☐Trouble swallowing
☐Tinnitus

Skin
☐Rash

Eyes
☐Eye pain
☐Visual disturbance

Respiratory
☐Sleep apnea
☐Chest tightness
☐Cough
☐Shortness of breath

Cardio
☐Chest pain
☐Leg swelling
☐Palpitations

Gastrointestinal
☐Abdominal pain
☐Blood in stool
☐Constipation
☐Diarrhea
☐Nausea
☐Vomiting

Endocrine
☐Cold intolerance
☐Excess fluid consumption
☐Excess urination

Genitourinary
☐Difficulty urinating
☐Pain during urination
☐Night-time urination
☐Flank pain
☐Frequency of urination
☐Blood in urine
☐Urgency of urination
☐Decreased urine volume

Muscle/Joint
☐Joint pains
☐Back pain
☐Gait problem
☐Joint swelling
☐Muscle pain

Allergy/Immuno
☐Immunocompromised
☐Environmental Allergies

Neurological
☐Dizziness
☐Light-headedness
☐Seizures
☐Fainting
☐Weakness

Hematologic
☐Bruises/Easy bleeding

Psychiatric
☐Confusion
☐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 that 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.

_______________________________________ Date:

Patient or Guardian's Signature

Name: Relation: