Patient Information
(Please Print)

Chose clinic because/Referred to clinic by **(please check one box):**

❑ Dr.________________________________ ❑ Insurance Plan ❑ Hospital ❑ Family ❑ Friend ❑ Yellow Pages ❑ Other

Primary Care Physician: ____

Name: ____
(Last) (First) MI

DOB: _____________ Age: ______ SS# ______________________SEX: ❑ M ❑ F Status: ❑ S ❑ M ❑ D ❑W
Address:

____
(Street)

____
(City) (State) (Zip)

Home Phone:(______)-_____________________ Cell Phone (_______)-_________________________

<u>Employment</u>
Employer: ____ Work Phone:(_______)-_______________
Address:

____
(Street)
`
____
(City) (State) (Zip)
<u>Emergency Contact</u>

( )
____
(Name) (Phone) (Relationship)
<u>Insurance</u>
<u>Primary</u> Insurance Company:____

Insurance Address:____

Policy #____ Group #______________________________

Cardholder:__________________________ Insurance Phone :_____________________________________

<u>Secondary</u> Insurance Company:____

Insurance Address:____

Policy #____ Group #______________________________

Cardholder: _________________________ Insurance Phone: _____________________________________
I herby consent to treatment by the physicians and/or associates of North Texas Kidney Consultants.

Signature: ____Date:________________________________
I herby assign my insurance benefits to be paid directly to North Texas Kidney Consultants.
I understand that I am financially responsible for all charges not covered by this assignment.

Signature: ____Date_______________________________

HEALTH HISTORY

Name: ____ **DOB:** ______________

Home Phone: ___________________________ **WorkPhone:** _______________________________

Current Medications

Medication	Dose	How often	Medication	Dose	How often

Do you take? ☐ Herbal Products ☐ Vitamins ☐ Nutrition supplements ☐ NSAIDs (Advil, Motrin, etc)

Allergies ☐ **None** (list allergies below)

Medication	Reaction (Rash, hives, etc)	Medication	Reaction (Rash, hives, etc)

☐ High blood pressure	☐ Diabetes	☐ Asthma	☐ Kidney Stones
☐ Heart Attack	☐ Cancer ___________	☐ Emphysema	☐ Urinary Tract Infection
☐ Heart Disease (other)	☐ HIV/AIDS	☐ Anemia	☐ Other Kidney Disease
☐ Stroke	☐ Thyroid disease	☐ Sickle Cell disease	☐ Liver disease
☐ Other			

Past Surgeries (list with year of surgery)

Surgery	Date	Surgery	Date

Family History

Relation	Living?	Age	High BP	Heart Dis.	Stroke	Cancer	Kidney Problems	Other (describe)
Father	Y / N		☐	☐	☐	☐	☐	
Mother	Y / N		☐	☐	☐	☐	☐	
Brother/Sister								
M / F	Y / N		☐	☐	☐	☐	☐	
M / F	Y / N		☐	☐	☐	☐	☐	
M / F	Y / N		☐	☐	☐	☐	☐	
Children								
M / F	Y / N		☐	☐	☐	☐	☐	
M / F	Y / N		☐	☐	☐	☐	☐	
M / F	Y / N		☐	☐	☐	☐	☐	

Other disease in your family? (check those that apply)

☐ Asthma	☐ Sickle Cell	☐ Leukemia	☐ Other
☐ Diabetes	☐ Thyroid problem	☐ Bleeding problem	

Social History

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other Occupation ______________________________

Do you use tobacco? Yes / No / Quit ☐ Cigarettes ☐ Cigars ☐ Chewing Tobacco ☐ Snuff How Much? ___________

Do you drink alcohol? Yes / No / Quit ☐ Beer ☐ Wine ☐ Mixed Drinks How many drinks per week? _____________

Recreational drug use? Yes / No / Quit

Review of Systems

General	Weight Loss / Gain	☐ Yes	☐ No	**Fevers / Chills**	☐ Yes	☐ No
	Loss of Appetite	☐ Yes	☐ No	**Night Sweats**	☐ Yes	☐ No
	Fatigue	☐ Yes	☐ No		☐ Yes	☐ No
Eyes	Glasses or contacts	☐ Yes	☐ No	**Blurry Vision**	☐ Yes	☐ No
	Glaucoma	☐ Yes	☐ No	**Cataracts**	☐ Yes	☐ No
ENT	Hearing difficulty	☐ Yes	☐ No	**Ringing in ears**	☐ Yes	☐ No
	Nosebleeds	☐ Yes	☐ No	**Sinus problems**	☐ Yes	☐ No
	Sore throat / Mouth sores	☐ Yes	☐ No	**Difficulty swallowing**	☐ Yes	☐ No
	Hoarseness / Voice change	☐ Yes	☐ No	**Unusual or metallic taste**	☐ Yes	☐ No
Cardiovasc.	Chest pain / tightness	☐ Yes	☐ No	**Shortness of breath**	☐ Yes	☐ No
	Irregular heartbeat	☐ Yes	☐ No	**Difficulty walking stairs / hill**	☐ Yes	☐ No
	Swelling in hands or feet	☐ Yes	☐ No	**Leg pain or cramps with walking**	☐ Yes	☐ No
Respiratory	Persistent Cough	☐ Yes	☐ No	**Wheezing**	☐ Yes	☐ No
	Blood in sputum	☐	☐	**Exposure to tuberculosis**	☐	☐ No

		Yes	No		Yes	

GI	Nausea / vomiting	☐ Yes	☐ No	**Diarrhea**	☐ Yes	☐ No
	Black or bloody stools	☐ Yes	☐ No	**Constipation**	☐ Yes	☐ No
	Frequent heartburn	☐ Yes	☐ No	**Hemorrhoids**	☐ Yes	☐ No
Urinary	Blood in urine	☐ Yes	☐ No	**Foamy urine**	☐ Yes	☐ No
	Burning with urinating	☐ Yes	☐ No	**Straining to urinate/weak stream**	☐ Yes	☐ No
	Urinate more that once at night	☐ Yes	☐ No	**Kidney stone**	☐ Yes	☐ No
	Frequent kidney infections	☐ Yes	☐ No	**Leaking bladder**	☐ Yes	☐ No
Musculo-Skeletal	Muscle pain or weakness	☐ Yes	☐ No	**Bone / Joint pain**	☐ Yes	☐ No
	Arthritis	☐ Yes	☐ No	**Gout**	☐ Yes	☐ No
Skin	Rashes / Sores	☐ Yes	☐ No	**Abnormal moles / pigment**	☐ Yes	☐ No
Neurologic	Seizures	☐ Yes	☐ No	**Numbness**	☐ Yes	☐ No
	Headaches	☐ Yes	☐ No	**Dizziness/vertigo/balance prob.**	☐ Yes	☐ No
Psychiatric	Depression	☐ Yes	☐ No	**Trouble sleeping**	☐ Yes	☐ No
	Suicidal thoughts	☐ Yes	☐ No	**Mood disorders**	☐ Yes	☐ No
Hematologic	Easy bruising	☐ Yes	☐ No	**Bleeding/clotting problems**	☐ Yes	☐ No
	Anemia	☐ Yes	☐ No	**Abnormal lymph nodes**	☐ Yes	☐ No
Endocrine	Excess thirst	☐ Yes	☐ No	**Heat or cold intolerance**	☐ Yes	☐ No
	Recent hair loss or growth	☐ Yes	☐ No	**Low blood sugars**	☐ Yes	☐ No
MEN Only	Erection difficulties	☐ Yes	☐ No	**Penile discharge**	☐ Yes	☐ No
	Testicle pain	☐ Yes	☐ No	**Testicle mass**	☐ Yes	☐ No
WOMEN Only	Abnormal PAP	☐ Yes	☐ No	**Vaginal discharge**	☐ Yes	☐ No
	Breast lump/mass/discharge	☐ Yes	☐ No	**Hot flashes**	☐ Yes	☐ No

North Texas Kidney Consultants

PRIVACY PRACTICES NOTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.

Summary of Privacy Practices

We may use and disclose your medical information, without your permission, for treatment, payment, and health care operations activities and, when required or authorized by law, for public health and interest activities, law enforcement, judicial and administrative proceedings, research, and certain other public benefit functions.

We may disclose your medical information to your family members, friends, and others you involve in your health care or payment for health care, and to appropriate public and private agencies in disaster relief situations.

We will not otherwise use or disclose your medical information without your written authorization. You have the right to examine and receive a copy of your medical information, to receive an accounting of certain disclosures we may make of your medical information, and to request that we amend, further restrict use and disclosure of, or communicate in confidence with you about your medical information.

Please review this entire notice for details about the uses and disclosures we may make of your medical information, about your rights and how to exercise them, and about complaints regarding or additional information about our privacy practices.

Please specify the name of family or friends that the practice can speak with regarding medical or financial information.

Name	Relationship	Date

Patient Name: ______________________________ **DOB:** ___________________

Signature: __________________________________ **Date:** ___________________

Signature if not patient: _______________________ **Date:** ___________________

Authorization For Release of Medical Records

North Texas Kidney Consultants
3030 Matlock Road
Suite 205
Arlington, Texas 76015

PHONE:(817) 375-0610 FAX:(817) 375-0640

Patient Name ____

SS#: ______________________________ **DOB:**______________________________

Receive Records From:

____
____
____
____

Release Records To:

____
____
____
____

Please send a copy of my records as indicated for date(s) of treatment: ____________________

_____**Hospital Records** _____**Lab Reports** _____ **Imaging Reports** _____ **Office Notes** _____**All Records**

Purpose for releasing
Medical information:____

____

____
Signature of Patient/Legal Guardian **Date**

____
Witness **Date**

This authorization expires ninety(90) days from the date of signature.

North Texas Kidney Consultants
<u>"Promoting Life Through Comprehensive Kidney Care"</u>

Please help us keep your Doctor's informed of your visits by providing the names of the Doctor's you are currently under the care of.

Pt.____SS#_________ - ________ - _________
DOB: _________/________/________

Dr. ____Primary Care Provider
Phone: ____Fax:___________________________

Dr. ____Primary Care Provider
Phone: ____Fax:___________________________

Dr. ____Primary Care Provider
Phone: ____Fax:___________________________

Dr. ____Primary Care Provider
Phone: ____Fax:___________________________

Dr. ____Primary Care Provider
Phone: ____Fax:___________________________

Dr. ____Primary Care Provider
Phone: ____Fax:___________________________

Dr. ____Primary Care Provider
Phone: ____Fax:___________________________

X____
Patient's signature authorizing release of records.
☐ **Not under care of any other Doctor's**