NORTH TEXAS KIDNEY CONSULTANTS

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 (_____)-_____

Employment
Employer: _____ Work Phone:(_____)-_____
Address:

_____
(Street)
`
_____
(City) (State) (Zip)

Emergency Contact

_____ (_____) _____
(Name) (Phone) (Relationship)

Insurance
Primary Insurance Company:_____

Insurance Address:_____

Policy #_____ Group #_____

Cardholder:_____ Insurance Phone :_____

Secondary 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_____

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KIDNEY CONSULTANTS

HEALTH HISTORY

Name: _____ **DOB:** _____

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

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 *(if yes please circle)*	☐ Yes	☐ No	**Fevers**	☐ Yes	☐ No
	Loss of Appetite	☐ Yes	☐ No	**Chills**	☐ Yes	☐ No
	Fatigue	☐ Yes	☐ No	**Night Sweats**	☐ 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	☐ Yes	☐ No	**Exposure to tuberculosis**	☐ Yes	☐ No

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

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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: _____

NORTH TEXAS
KIDNEY CONSULTANTS

Authorization For Release of Medical Records
North Texas Kidney Consultants

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
"Promoting Life Through Comprehensive Kidney Care"

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. _____Specialty
Phone: _____Fax:_____

Dr. _____Specialty
Phone: _____Fax:_____

Dr. _____Specialty
Phone: _____Fax:_____

Dr. _____Specialty
Phone: _____Fax:_____

Dr. _____Specialty
Phone: _____Fax:_____

Dr. _____Specialty
Phone: _____Fax:_____

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