Appointment Scheduled:
Office Location: ____________________
Date: ________________ Time: ________
Reason for referral: ____________________

PATIENT INFORMATION

Name: ______________________________ Date of Birth: ____________________

Address: ______________________________ City: ____________ Zip: __________

Home Phone: ______________________________ Work Phone: ____________________

Social Security #: ______________________________ Marital Status: ______________ Sex: ____

Occupation (indicate if student): ______________________________ Spouse's Name: ____________________

In case of Emergency contact: ______________________________ Phone: ____________________

Family Doctor: ______________________________ Phone: ____________________

INSURANCE

Primary Insurance: ______________________________ Policy #: ____________________

Name of Policyholder: ______________________________ Group #: ____________________

Secondary Insurance: ______________________________ Policy #: ____________________

Name of Policyholder: ______________________________ Group #: ____________________

In order to control our cost of billing, we request payment at the time of service.

I hereby authorize the office of Advanced Kidney Care Medical Associates to release any medical information required in the course of examination and treatment and permit payment directly to them any benefits due for their services rendered. I recognize and accept responsibility for services rendered regardless of insurance coverage. This includes, but is not limited to co-insurance, co-payments, deductibles, and non-covered services. I permit a copy of this authorization to be used in place of the original.

Signature: ______________________________ Date: ____________________

I, ____________________, reviewed information above and verify that all demographics are the same

on this form Signature: ______________________________ Date: ____________________

I, ____________________, reviewed information above and verify that all demographics are the same

on this form Signature: ______________________________ Date: ____________________

I, ____________________, reviewed information above and verify that all demographics are the same

on this form Signature: ______________________________ Date: ____________________

revised 09/15/2005

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE AND CONSENT TO USE AND DISCLOSE HEALTH INFORMATION

Read before signing the Acknowledgement and Consent

This acknowledgement of notice and consent authorizes Advanced Kidney Care Medical Associates to use and disclose health information about you for treatment, payment, and health care operations purposes.

Notice of Privacy Practices. Advanced Kidney Care Medical Associates has a Notice of Privacy Practices, which describes how we may use and disclose your protected health information and how you can access your protected health information and exercise other rights concerning your protected health information. You may review our current notice prior to signing this acknowledgement and consent.

Amendments. We reserve the right to change our Notice of Privacy Practices and to make the terms of any change effective for all protected health information that we maintain, including information created or obtained prior to the date of the effective date of the change. You may obtain a revised notice by submitting a written request to our Privacy Officer.

How to contact our Privacy Officer

Mail:	Address to: Advanced Kidney Care Medical Associates Attention: Privacy Officer, 4564 Penn Avenue, Pittsburgh, PA 15224
Telephone:	(412) 683-1278
Facsimile:	(412) 683-6992

Acknowledgement and Consent

Print or type all information except the signature.

I have received the Notice of Privacy Practices for Advanced Kidney Care Medical Associates. Advanced Kidney Care Medical Associates is authorized to use and disclose health information about ________________________________ (patient name) for treatment, payment, and healthcare operations purposes consistent with its Notice of Privacy Practices.

____
Signature of patient
(or patient's personal representative)

____
Date of receipt

____
Name of personal representative

____
Relationship to patient (or other authority)

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MEDICAL HISTORY

Date:

Please answer these questions concerning your health status. This general information will help your doctor take better care of you. Of course, all information is confidential.

Patient Name: | Height: | Weight:

Family Physician: | Physicians Phone Number:

Please list any present medical condition for which you are currently being treated. If none, please check none. ☐ None

Please list any surgeries or hospitalizations you have had in the past. If none, please check none. ☐ None

Do you??? (Please answer each question)

YES	NO		
☐	☐	Smoke cigarettes?	___ packs per day?
☐	☐	Chew tobacco?	How much?
☐	☐	Drink Beer?	___ bottles per ___
☐	☐	Drink Wine?	___ oz. per ___
☐	☐	Drink Hard Liquor?	___ oz. per ___
☐	☐	Drink regular coffee?	If so, cups/day?
☐	☐	On a special diet?	What type?

Allergies to Medications

None ☐

Medication	What type of reaction?

Family Health History

Do these problems run in your family?

(Please mark an "X" in the spaces provided below that apply to your family history)

	Father	Mother	Father's Father	Father's Mother	Mother's Father	Mother's Mother	Brothers	Sisters	Other
Diabetes									
Heart Disease									
High Blood Pressure									
Stroke									
Cancer									
Gallbladder Disease									
Ulcer, Colitis, Crohn's									
Asthma/Respiratory									
Thyroid Disease									
Bleeding Disorders									
Kidney Disease									

Study of Systems

Please place an "X" beside those conditions which affect you. . .

GENERAL

_____ Fainting
_____ Unexpected Weight Loss
_____ Recent Weight Gain
_____ Fever or Shaking Chills
_____ Night Sweats
_____ Swollen Glands
_____ Other _______________

SKIN

_____ Severe Itching
_____ Persistent Rash
_____ Changing Moles
_____ Psoriasis
_____ Other _______________

HEAD

_____ Glaucoma
_____ Cataracts
_____ Severe Headaches
_____ Double Vision
_____ Difficulty Hearing
_____ Ringing in Ears
_____ Wear Hearing Aid
_____ Wear Dentures
_____ Loose Teeth
_____ Removable Bridge
_____ Bleeding Gums
_____ Severe Nosebleeds
_____ Frequent Sore Throats
_____ Persistent Hoarseness
_____ Other _______________

/BLOOD

_____ Blood Transfusion Past 6 Months
_____ Prolonged Bleeding from Surgery
_____ Anemic in Past
_____ Ever Treated for Cancer
_____ Think I'm at High Risk for AIDS
_____ Coumadin Use
_____ Other _______________

MUSCLES AND JOINTS

_____ Muscle Cramps
_____ Muscle Weakness
_____ Arthritis or Joint Pain
_____ Frequent Back Pain
_____ Other _______________

HEART AND LUNGS

_____ High Blood Pressure
_____ Heart Attack in Past
_____ Heart Murmur
_____ Mitral Valve Prolapse
_____ Artificial Valve
_____ Rheumatic Fever as Child
_____ Heart Disease
_____ High Cholesterol
_____ Fainting Spells
_____ Irregular Heartbeat
_____ Wear Pacemaker
_____ Chest Pain
_____ Shortness of Breath
_____ Can't Breath When Flat
_____ Awaken Short of Breath
_____ Ankles Swell
_____ Frequent Cough
_____ Cough up Sputum
_____ Cough up Blood
_____ Wheezing or Asthma
_____ Other _______________

NEUROLOGICAL

_____ Epilepsy or Seizures
_____ Past Stroke
_____ Other _______________

DIGESTIVE TRACT

_____ Hiatal Hernia in Past
_____ Ulcers in Past
_____ Colon Polyps in Past
_____ Colon Cancer in Past
_____ Liver Disease or Jaundice
_____ Poor Appetite
_____ Nausea
_____ Vomiting
_____ Frequent Heartburn
_____ Heartburn Awakens
_____ Trouble Swallowing
_____ Rectal Bleeding
_____ Black Bowel Movements
_____ Vomited Blood
_____ Abdominal Pain
_____ Diarrhea
_____ Lost Bowel Control or Soiling
_____ Constipation
_____ Bowel Habit Unpredictable
_____ Milk or Lactose Intolerance
_____ Gallstones
_____ Other _______________

KIDNEYS

_____ Kidney Stones
_____ Kidney Disease
_____ Frequent Urination
_____ Up Nights to Urinate
_____ Blood in Urine
_____ Painful Urination
_____ Slow Urination
_____ Leakage of Urine
_____ Other _______________

EMOTIONS

_____ Often Depressed
_____ Cry Easily
_____ Overly Anxious
_____ Can't Handle Stress
_____ Other _______________

EXPOSURE TO
- Infectious Disease -

_____ TB
_____ Rheumatic Fever
_____ Gonorrhea
_____ Syphilis
_____ Measles
_____ Mumps
_____ Chicken Pox
_____ Whooping Cough
_____ Contagious Disease
_____ Other _______________

MEN ONLY

_____ Lump in Testicles
_____ Penis Discharge
_____ Erection Difficulties
_____ Other _______________

WOMEN ONLY

_____ Pregnant Now
_____ Planning Pregnancy
_____ Nipple Discharge
_____ Lump in Breast
_____ Vaginal Discharge
_____ Hot Flashes
_____ Non-period Bleeding
_____ Past Menopause
_____ Painful Intercourse
_____ Painful Periods
_____ Change in Periods
_____ Past Endometriosis
_____ Other _______________

_______________ Date

_______________ Signature of Patient or Responsible Party

Advanced Kidney Care Medical Associates

Patient Instructions Regarding PHI

I authorize my Physician, Physician Group or Staff member employed by the Practice to release any and all medical test results or other medical information relating to my treatment to: (Initial all choices that apply)

_________ May leave a message at work to call the physician's office.

_________ May leave a message with a family member for me to call the physician's office.

_________ May give test results/instructions to:

Designee's Name: ______________________________

Relationship: ______________________________

_________ May only release test results to the patient

_________ Other: ______________________________

____

I understand this information used and these instructions will be in effect unless changed Or revoked by me either in writing or by completing a new instruction form.

______________________ Date

______________________ Patient (legal representative) Signature