INDIANA NEPHROLOGY & INTERNAL MEDICINE, P.C.

PATIENT INFORMATION

PATIENT NAME:_____ SEX:_____ DOB:_____

SOCIAL SECURITY NUMBER:_____ FAMILY CARE PHYSICIAN:_____

ADDRESS:_____

CITY:_____ STATE:_____ ZIP:_____

HOME PHONE:_____ CELL:_____ WORK:_____

MARITAL STATUS: _____Married - Single - Widowed - Divorced - Minor_____ EMAIL:_____

OCCUPATION:_____ EMPLOYER:_____

PREFERRED METHOD OF CONTACT:___(Circle One) Phone Mail Both___ ETHNICITY: _(Circle One) Hispanic - Non-Hispanic_

RACE: ___(Circle One) Caucasian - African American - Hispanic - Asian - American Indiana - Other_____

UNINSURED

I do not have insurance and understand that I am financially responsible for the charges incurred.

Patient Signature:_____

PRIMARY INSURANCE

PRIMARY INSURANCE COMPANY:_____

POLICY HOLDER NAME:_____ DOB:_____

SOCIAL SECURITY NUMBER:_____ RELATIONSHIP TO PATIENT:_____

POLICY ID:_____ GROUP:_____

SECONDARY INSURANCE (If Applicable)

PRIMARY INSURANCE COMPANY:_____

POLICY HOLDER NAME:_____ _____ DOB:_____

SOCIAL SECURITY NUMBER:_____ RELATIONSHIP TO PATIENT:_____

POLICY ID:_____ GROUP:_____

FINANCIAL AGREEMENT/CONSENT TO FILE INSURANCE

I hereby agree to be responsible for charges covering all services rendered by Indiana Nephrology & Internal Medicine, PC. I shall also be responsible for any legal and/or attorney fees required to collect for these services, to which interest may be added at the current legal rate. I hereby assign directly to Indiana Nephrology & Internal Medicine, PC and Physicians payment of my health insurance benefits applicable to these services and authorize the collection of such funds on my behalf. Such payments shall not exceed my balance owed to Indiana Nephrology & Internal Medicine, PC. I acknowledge and understand that I and any guarantor signing on my behalf are personally responsible for all charges not otherwise paid by assignment to insurance benefits. I also certify that any information which I have given in applying for coverage under the Social Security Act, or any insurance or other information, which I have provided, is true and correct. If I provide Indiana Nephrology & Internal Medicine, PC or its agents with my cell phone number, I authorize Indiana Nephrology & Internal Medicine, PC or its agents to call my cell phone either manually or by auto-dialer in order to collect any amounts I owe. I understand that any e-mail I provide is my personal e-mail and I authorize Indiana Nephrology & Internal Medicine, PC or its agents to contact me via that e-mail address.

SIGNATURE OF RESPONSIBLE PARTY/PATIENT SIGNATURE

PATIENT SIGNATURE:_____ DATE:_____ STAFF INITIALS:_____

GENERAL CONSENT TO MEDICAL TREATMENT

I request and authorize Indiana Nephrology & Internal Medicine, PC, their physicians, their associates and assistants who may attend to me during any visit, to provide drugs, medical care and other services as prescribed for me for my health and well-being. I acknowledge that no representations, warranties, or guarantees as to the results have been made to me by Indiana Nephrology & Internal Medicine, PC nor have I relied upon any such representations, warranties, or guarantees.

INITIALS:_____ DATE:_____

PATIENT NAME: _____ DOB: _____

MISSED APPOINTMENTS

I hereby agree to be responsible for a charge of $50.00, which may be assessed by Indiana Nephrology & Internal Medicine, PC for appointments missed or cancelled with less than 24 hour notice. I understand these charges will not be submitted to my insurance.

INITIALS:_____ DATE:_____

COMMUNICATION OF PRIVATE HEALTH INFORMATION AUTHORIZATION

Please check and fill out all that are acceptable forms of communication to provide quality patient care.

- ☐ I authorize the staff of Indiana Nephrology & Internal Medicine, PC and/or the iremind system to leave a message regarding my private health information on my home voicemail or answering machine.
- ☐ I authorize the staff of Indiana Nephrology & Internal Medicine, PC and/or the iremind system to leave a message regarding my private health information on my cell phone voicemail.
- ☐ I authorize the staff of Indiana Nephrology & Internal Medicine, PC to leave a message regarding my private health information on my work voicemail or answering machine.
- ☐ I authorize the staff of Indiana Nephrology & Internal Medicine, PC to speak with the following individuals to discuss medical and/or financial information.

Medical:

Name	Phone Number	Relationship to Patient
_____	_____	_____
_____	_____	_____

Financial:

Name	Phone Number	Relationship to Patient
_____	_____	_____
_____	_____	_____

Emergency Contact: (Please list one individual not living at the same address)

Name	Phone Number	Relationship to Patient
_____	_____	_____
_____	_____	_____

All information signed and authorized by me on this form shall remain in effect until my written revocation

INITIALS:_____ DATE:_____

HIPAA PRIVACY NOTICE ACKNOWLEDGEMENT

By signing below, I acknowledge that I have been advised of the Notice of Privacy Practices of Indiana Nephrology & Internal Medicine, PC and may obtain a written copy upon request.

Patient Signature:_____ Date:_____

STAFF USE ONLY

Indiana Nephrology & Internal Medicine, PC personal witnessing form completion: _____

Date:_____

INDIANA NEPHROLOGY NEW PATIENT QUESTIONAIRE

Name: *(Last, First, M.I.)*	☐ M ☐ F	**DOB:**

PAST MEDICAL HISTORY – COMMON DISEASES

Do you have a personal history of any of the following?

Kidney Disease	☐ Kidney Disease Stage: 1 2 3 4 5	☐ Polycystic Kidney Disease ☐ Acute Kidney Failure
Diabetes	☐ Type 1 ☐ Type 2 ☐ Diabetic damage to your eyes ☐ Pain/Numbness /Tingling in your feet due to diabetes	☐ Type Unknown ☐ If yes, how long _____(yrs) ☐ Laser surgery to your eyes for diabetes
High Blood Pressure	☐ If yes, how long? _____yrs)	☐ White Coat Hypertension
Ischemic Heart Disease	☐ Heart attack ☐ Angina ☐ Angioplasty	☐ Coronary Stent ☐ CABG (Coronary Artery Bypass Graft) ☐ High Cholesterol
Cancer	☐ Type _____	☐ Treatment _____
Stroke	☐ Stroke	☐ TIA
Gout	☐ Gout	☐ Treatment _____

PAST MEDICATION USE

Do you now or have you ever taken any of the following medications?

☐ Advil ☐ Ibuprofen ☐ Motrin ☐ Aleve ☐ Indomethacin ☐ Ketoprofen ☐ Daypro ☐ Gold	☐ Naproxen ☐ Naprosyn ☐ Feldene ☐ Voltaren ☐ Anaprox ☐ Ansaid ☐ Clinoril	☐ Bextra ☐ Vioxx ☐ Celebrex ☐ Diclofenac ☐ Lodine ☐ Piroxicam ☐ Relafen ☐ None of the Above

SIGNIFICANT EXPOSURE TO METALS/CHEMICALS

Are you aware of any significant exposure to:

	☐ Lead ☐ Benzene	☐ Carbon Tetrachloride ☐ Other _____

PAST MEDICAL HISTORY – ADDITIONAL CONDITIONS

Do you have a personal history of any of the following?

EENT	☐ Blindness ☐ Cataracts	☐ Hearing Problems ☐ Glaucoma
Cardiovascular	☐ Atrial Fibrillation ☐ Pacemaker ☐ AICD (Cardiac Defibrillator) ☐ Stents	☐ Valvular Heart Disease ☐ Congestive Heart Failure ☐ Bypass
Respiratory	☐ COPD ☐ Asthma ☐ Emphysema	☐ Tuberculosis ☐ Sleep Apnea
Gastrointestinal	☐ GERD (Gastric Reflux) ☐ Stomach/Bowel Ulcers ☐ Gall Bladder Disease ☐ Hepatitis ☐ Crohn's Disease	☐ Inflammatory Bowel Disease ☐ Irritable Bowel Syndrome ☐ Gluten Intolerance ☐ Lactose Intolerance ☐ Ulcerative Colitis
Genitourinary	☐ Enlarged Prostate ☐ Kidney Stones	☐ Frequent UTIs (Urinary Tract Infections)
OB History	☐ Preeclampsia ☐ Hypertension during pregnancy	☐ Gestational Diabetes ☐ History of Complicated Pregnancy
Musculoskeletal	☐ Osteoarthritis	☐ Osteoporosis
Neurological	☐ Multiple Sclerosis ☐ Seizures	☐ Parkinson's ☐ Dementia
Psychiatric	☐ Depression	☐ Anxiety Disorder
Endocrine	☐ Hypothyroidism ☐ Hyperthyroidism	☐ Adrenal Insufficiency
Hematology	☐ Anemia ☐ Sickle Cell Disease	☐ Blood Transfusion
Immuno/Allergy	☐ HIV ☐ AIDS	☐ Rheumatoid Arthritis ☐ Lupus

PAST MEDICAL HISTORY – SURGERY HISTORY

Have any of the following surgeries been performed on you?

☐ Appendectomy	☐ Hip Replacement	☐ Renal Transplant
☐ CABG	☐ Left ☐ Bilateral	☐ Thyroidectomy
☐ Carotid Endarterectomy	☐ Right	☐ Tonsillectomy
☐ Cataract Surgery	☐ Knee Replacement	☐ Valve Replacement
☐ D & C	☐ Left ☐ Bilateral	☐ AV Fistula
☐ Gall Bladder Removal	☐ Right	☐ AV Graft
☐ Gastric Bypass	☐ Hysterectomy	☐ PD Catheter
☐ Hemorrhoidectomy	☐ Prostatectomy	☐ Other_____
☐ Hernia Repair	☐ Nephrectomy	

Other Health Problems Not Listed Above:

FAMILY HISTORY – ILLNESSES

Do the following family members have any of the following medical conditions?

Kidney Disease	☐ Father ☐ Mother	☐ Sibling ☐ Child
Diabetes	☐ Father ☐ Mother	☐ Sibling ☐ Child
High Blood Pressure	☐ Father ☐ Mother	☐ Sibling ☐ Child
Ischemic Heart Disease	☐ Father ☐ Mother	☐ Sibling ☐ Child
Cancer	☐ Father ☐ Mother	☐ Sibling ☐ Child
Stroke	☐ Father ☐ Mother	☐ Sibling ☐ Child
Gout	☐ Father ☐ Mother	☐ Sibling ☐ Child
ADPKD	☐ Father ☐ Mother	☐ Sibling ☐ Child
Dementia	☐ Father ☐ Mother	☐ Sibling ☐ Child

FAMILY HISTORY – STATUS

Father	☐ Living ☐ Unknown	☐ Deceased ☐ Age at Death:_____ ☐ Cause of Death:_____
Mother	☐ Living ☐ Unknown	☐ Deceased ☐ Age at Death:_____ ☐ Cause of Death:_____

Other Family History Not Listed Above:

SOCIAL HISTORY – GENERAL

Current Marital Status	☐ Married ☐ Separated ☐ Single	☐ Widowed ☐ Divorced
Children	☐ How many children do you have? _____	
Living Arrangement	☐ Alone ☐ Family Member ☐ Spouse	☐ In Home Caregiver ☐ Significant Other ☐ Assisted Living Facility

Occupation	☐ Retired
	☐ Unemployed
	☐ Disabled
	☐ Employed
	  ☐ Full - time
	  ☐ Part - time
	☐ Student
	
	List your Current or Former Occupation:_____	

Deficits	☐ Hearing Loss ☐ Limited Mobility	☐ Poor Vision or Blindness ☐ Transportation Challenges

SOCIAL HISTORY – HABITS

Tobacco Use	☐ Current or Former User
	  ☐ Cigarettes
	  ☐ Chewing Tobacco
	  ☐ Pipes
	  ☐ Snuff
	  ☐ Cigars
	
	If a former user, what year did you quit?
	_____
		☐ Never Used
		☐ Unknown

	Complete the following section if you are a current or former cigarette user: How often do you currently smoke or how often did you smoke before you quit? ☐ Every Day ☐ Some Days ☐ Unknown How many packs per day do you currently smoke or how many packs per day did you smoke before you quit? _____ How many total years have you used cigarettes? _____	
Alcohol Use	☐ Current or Former User ☐ Never Used ☐ Occasional ☐ 1-2 per Day ☐ 3 or more per Day If a former user, what year did you quit? _____	
Recreational Drug Use	☐ Current or Former User ☐ Marijuana ☐ Amphetamines ☐ LSD ☐ Heroin ☐ Ecstasy ☐ Never Used If a former user, what year did you quit? _____	☐ Opium ☐ Cocaine ☐ Barbiturates ☐ Other _____

Other Social History Not Listed Above:

INDIANA NEPHROLOGY & INTERNAL MEDICINE, P.C.

In order to provide the best care possible please let us know if you have experienced any of the following in the last three months

Patient Name: _____ Date:_____

Circle those that apply

Constitutional:	Fever Weight gain Weight loss	Fatigue Chills Weakness	Genitourinary:	Urinary urgency Urinary burning or pain Blood in urine Urinary frequency	Urinary hesitancy (trouble starting) Foamy urine Incontinence Nocturia (peeing at night)
HEENT:	Vision impaired Eye pain Redness Color blindness Double vision Hearing loss Ear pain	Sinus problems Sore throat Nose bleeds Headache Hoarseness Tinnitus (ringing in your ears) Vertigo (spinning sensation)	Musculoskeletal:	Back pain Neck pain Joint pain	Muscle pain Arm weakness Leg weakness
Respiratory:	Shortness of breath Shortness of breath at rest Shortness of breath with activity Pain with breathing	Cough Wheezing Blood in sputum (when you cough) Night sweats	Skin:	Rash Itching Scaling	Dryness Color change
			Neurological:	Numbness Tremors Seizures	Tingling Fainting
Cardiovascular:	Chest pain Palpitations Claudication (painful legs with activity)	Orthopnea (shortness of breath while laying down) Edema (swelling)	Psychiatric:	Depression Insomnia	Anxiety
			Endocrine:	Heat intolerance Cold Intolerance	Excessive thirst Excessive urination
Gastrointestinal:	Abdominal Pain Nausea Diarrhea Heartburn Vomiting	Constipation Anorexia Trouble swallowing Indigestion	Hematology:	Bleeding gums	Easy bruising
			Immuno/Allergy:	Seasonal allergies	Hives

Patient Signature: _____

INDIANA NEPHROLOGY & INTERNAL MEDICINE, P.C.

Patient Name _____ Date _____

Pharmacy _____

Please list all your allergies (drug, food, dyes, etc) and the reactions you have to these:
___ I have no allergies that I'm aware of.
___ I have the following allergies and reactions:
_____
_____
_____

Please list all of your current medications (including supplements):

Drug	MG	Times/day	Drug	MG	Times /day