



## MIDWEST NEPHROLOGY CONSULTANTS, P.A. Disclosure Policies

### Authorization & Assignment

Please read carefully

I hereby authorize Midwest Nephrology Consultants, P. A. and its' physicians to furnish to/or receive from CMS and its agents, insurance companies and other health care providers any and all information concerning my medical or physical condition, diagnosis or treatment.

I hereby assign payment of medical/ surgical benefits to Midwest Nephrology Consultants, P.A. for medical services rendered to myself or my dependents.

*I understand that I am financially responsible for all services rendered which are not covered by insurance.*

I also understand that if I elect to visit a specialist and receive specialty services without a valid written referral when one is required by my insurance, then I am solely responsible for payment of services rendered. I understand that I am responsible for furnishing valid referrals from my primary care physician.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

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### Disclosure of Social Security Number

Please read carefully

We value your privacy and understand your concern when asked to disclose such private information as your social security number. However- there are times we must have access to this information in order to process your insurance claims efficiently and correctly the first time.

It is your right to decline providing this information; however- please be advised; our billing staff will only make one attempt at filing the claim without this pertinent information. If, it is declined- our billing department will not pursue further collection thru the insurance company. The claim will be directly turned over to patient responsibility and prompt payment expected.

By signing below, you agree to and understand the information that has been stated above.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

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### Disclosure of Presentation and Scanning of your Drivers License

Please read carefully

In order to prevent any fraudulent use of your insurance card, Midwest Nephrology Consultants, P. A. will request permission to view and scan your driver's license.

*You have the right to refuse scanning of your driver's licenses.*

At each visit, Midwest Nephrology Consultants, P. A. will request that you present your driver's license for verification of identity.

By signing below, you agree to and understand the information that has been stated above.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

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All information provided is Confidential and will only be used to process treatments, payments and necessary operations of the medical practice and will be released only under strict HIPAA (Health Insurance Portability and Accountability Act) compliant guidelines.

# HEALTH QUESTIONNAIRE

**Dear Patient:**

Today's Date: \_\_\_\_\_

Please **print** and **complete** all information where applicable. The information on this form will help your Doctor provide you with better medical care. *All information will be treated as confidential unless you grant permission to release it.*

**Patient Name:** \_\_\_\_\_ Age: \_\_\_\_\_

**Address:** \_\_\_\_\_ City: \_\_\_\_\_

**Phone No:** (    ) \_\_\_\_\_ State/Zip: \_\_\_\_\_

**PAST MEDICAL HISTORY:**  
Surgical Operations & Year Performed:


Medical Illnesses & Year of Illness:


**FAMILY HISTORY CONT.:**

	If Living		If Deceased	
	Age	Health	Age	Cause
Father				
Mother				
Brothers				
Sisters				

**Allergies:**


**Injuries & Year of Injury:**


**SOCIAL HISTORY:**

Occupation: \_\_\_\_\_

Marital Status: \_\_\_\_\_

Number of Children: \_\_\_\_\_

Do You Drink Alcohol? \_\_\_\_\_

How Much? \_\_\_\_\_

Do You Smoke? \_\_\_\_\_

How Much?/How Long? \_\_\_\_\_

**FAMILY MEDICAL HISTORY:**  
Have Any *Blood Relatives* Ever Had the Following?

Please Circle:	Who?:	Please Circle:	Who?:
Anemia _____		High Blood Press _____	
Arthritis _____		Kidney Disorder _____	
Cancer _____		Lung Disease _____	
Diabetes _____		Mental Illness _____	
Epilepsy _____		Migrane _____	
Goiter _____		Stomach Ulcers _____	
Heart Trouble _____		Stroke _____	
		Tuberculosis _____	

**List All Medications You are Now Taking:**

Med Name	Dosage	time's daily
1. _____		
2. _____		
3. _____		
4. _____		
5. _____		
6. _____		
7. _____		
8. _____		
9. _____		
10. _____		

**TB ASSESSMENT:**

Persistent Cough/Coughing Blood?	
Unexplained Night Sweats, Wt Loss, Loss of Appetite or Fevers?	
Have you been exposed to friends/family with TB?	
Are you Foreign Born or Lived Abroad?	

11. _____		
12. _____		
13. _____		
14. _____		
15. _____		

**INITIALLY REVIEWED BY DR.** \_\_\_\_\_

**Date:** \_\_\_\_\_

Please circle Yes or NO to indicate any personal history experienced in the last *twelve months*

<b>DO YOU HAVE ALLERGIES:</b>			<b>YES</b>	<b>NO</b>	<b>RESPIRATORY:</b>	
If Yes, Please List: _____					Chronic or frequent coughs	<b>YES</b> <b>NO</b>
					Spitting up of blood	<b>YES</b> <b>NO</b>
					Shortness of breath	<b>YES</b> <b>NO</b>
<b>GENITOURINARY:</b>					Asthma or wheezing	<b>YES</b> <b>NO</b>
Frequent urination	<b>YES</b>	<b>NO</b>			Do You Snore?	<b>YES</b> <b>NO</b>
Burning/painful urination	<b>YES</b>	<b>NO</b>			Told You Have Sleep Apnea?	<b>YES</b> <b>NO</b>
Awaken at night to urinate	<b>YES</b>	<b>NO</b>	<b>GASTROINTESTINAL:</b>			
Blood in urine	<b>YES</b>	<b>NO</b>			Loss of appetite	<b>YES</b> <b>NO</b>
Change in urine stream force	<b>YES</b>	<b>NO</b>			Do you/have you ever had Hepatitis	<b>YES</b> <b>NO</b>
Incontinence or dribbling	<b>YES</b>	<b>NO</b>			Change in bowel habits	<b>YES</b> <b>NO</b>
Sores or discharge	<b>YES</b>	<b>NO</b>			Nausea or vomiting	<b>YES</b> <b>NO</b>
Kidney stones	<b>YES</b>	<b>NO</b>			Frequent diarrhea	<b>YES</b> <b>NO</b>
Sexual difficulty	<b>YES</b>	<b>NO</b>			Constipation	<b>YES</b> <b>NO</b>
<i>Male only:</i>					Painful bowel movements	<b>YES</b> <b>NO</b>
Testicle pain/lumps	<b>YES</b>	<b>NO</b>			Blood in stool	<b>YES</b> <b>NO</b>
<i>Female only:</i>					Abdominal pain	<b>YES</b> <b>NO</b>
Painful periods	<b>YES</b>	<b>NO</b>			Ulcer (stomach/duodenal)	<b>YES</b> <b>NO</b>
Irregular periods	<b>YES</b>	<b>NO</b>	<b>MUSCULOSKELETAL:</b>			
Vaginal discharge	<b>YES</b>	<b>NO</b>			Joint pain	<b>YES</b> <b>NO</b>
# of pregnancies	<b>YES</b>	<b>NO</b>			Joint stiffness or swelling	<b>YES</b> <b>NO</b>
# of miscarriages	<b>YES</b>	<b>NO</b>			Weakness in muscles/joints	<b>YES</b> <b>NO</b>
Date of last pap smear:					Muscle pain or cramps	<b>YES</b> <b>NO</b>
Date of last mammogram:					Back pain	<b>YES</b> <b>NO</b>
<b>GENERAL:</b>					Difficulty walking	<b>YES</b> <b>NO</b>
Recent weight changes	<b>YES</b>	<b>NO</b>			HU_YB G5=8 G.....	<b>YES</b> <b>NO</b>
Fevers	<b>YES</b>	<b>NO</b>	<b>SKIN:</b>			
Nightsweats	<b>YES</b>	<b>NO</b>			Rash or itching	<b>YES</b> <b>NO</b>
Fatigue	<b>YES</b>	<b>NO</b>			Change in skin color	<b>YES</b> <b>NO</b>
Weakness	<b>YES</b>	<b>NO</b>			Change in hair or nails	<b>YES</b> <b>NO</b>
<b>EYES:</b>					Varicose veins	<b>YES</b> <b>NO</b>
Eye disease or injury	<b>YES</b>	<b>NO</b>			Breast pain or lump	<b>YES</b> <b>NO</b>
Wear glasses/contact lenses	<b>YES</b>	<b>NO</b>			Nipple discharge	<b>YES</b> <b>NO</b>
Blurred or double vision	<b>YES</b>	<b>NO</b>	<b>NEUROLOGICAL:</b>			
Glaucoma	<b>YES</b>	<b>NO</b>			Frequent/recurring headaches	<b>YES</b> <b>NO</b>
Cataracts	<b>YES</b>	<b>NO</b>			Light headed or dizziness	<b>YES</b> <b>NO</b>
<b>EARS/NOSE/THROAT:</b>					Convulsions or seizures	<b>YES</b> <b>NO</b>
Hearing loss or ringing	<b>YES</b>	<b>NO</b>			Numbness or tingling	<b>YES</b> <b>NO</b>
Earaches or drainage	<b>YES</b>	<b>NO</b>			Shakes, paralysis, trembling	<b>YES</b> <b>NO</b>
Chronic sinus problems	<b>YES</b>	<b>NO</b>			Stroke	<b>YES</b> <b>NO</b>
Nose bleeds	<b>YES</b>	<b>NO</b>			Head injury	<b>YES</b> <b>NO</b>
Mouth sores	<b>YES</b>	<b>NO</b>	<b>PSYCHIATRIC:</b>			
Sore throat or voice change	<b>YES</b>	<b>NO</b>			Memory loss or confusion	<b>YES</b> <b>NO</b>
Swollen glands in neck	<b>YES</b>	<b>NO</b>			Nervousness	<b>YES</b> <b>NO</b>
<b>CARDIOVASCULAR:</b>					Depression	<b>YES</b> <b>NO</b>
Heart trouble	<b>YES</b>	<b>NO</b>			Difficulty sleeping	<b>YES</b> <b>NO</b>
Chest pain or angina pectoris	<b>YES</b>	<b>NO</b>	<b>HEMATOLOGIC/LYMPHATIC:</b>			
Palpitations	<b>YES</b>	<b>NO</b>			Slow to heal after cuts	<b>YES</b> <b>NO</b>
Swelling of ankles or hands	<b>YES</b>	<b>NO</b>			Bleeding/bruising tendency	<b>YES</b> <b>NO</b>
<b>ENDOCRINE:</b>					Anemia	<b>YES</b> <b>NO</b>
Glandular or hormone problem	<b>YES</b>	<b>NO</b>			Blood clot	<b>YES</b> <b>NO</b>
Thyroid disease	<b>YES</b>	<b>NO</b>			Transfusions	<b>YES</b> <b>NO</b>
Diabetes(insulin/non-insulin)	<b>YES</b>	<b>NO</b>			Enlarged glands	<b>YES</b> <b>NO</b>
Excessive thirst/urination	<b>YES</b>	<b>NO</b>	<b>RECENT SURGICAL:</b>			
Heat or cold intolerance	<b>YES</b>	<b>NO</b>			General	<b>YES</b> <b>NO</b>
					Vascular	<b>YES</b> <b>NO</b>
					Dental	<b>YES</b> <b>NO</b>
					Eyes	<b>YES</b> <b>NO</b>

INITIALLY REVIEWED BY DR. \_\_\_\_\_

Patient Name:

Date: