NEW PATIENT- REVIEW OF SYSTEMS

CHECK ALL THAT APPLY TO YOU

GENERAL:
- FEVER
- NIGHTSWEATS
- WEAKNESS
- FATIGUE
- RECENT WEIGHT CHANGES (DECREASED)
- RECENT WEIGHT CHANGES (INCREASED)

SKIN:
- RASH
- ITCHING
- CHANGE IN HAIR
- CHANGE IN NAILS
- VARICOSE VEINS
- CHANGE IN SKIN COLOR
- THINNING HAIR
- BREAST PAIN
- NIPPLE DISCHARGE

CARDIOVASCULAR:
- CHEST PAIN
- PALPITATIONS
- SWELLING OF HANDS
- SWELLING OF ANKLES
- HEART TROUBLE
- PAIN IN CALVES WHEN WALKING

GASTROINTESTINAL:
- NAUSEA
- VOMITTING
- BLOOD IN STOOL
- CONSTIPATION
- FREQUENT DIARRHEA
- LOSS OF APPETITE
- CHANGE IN BOWEL HABITS
- DO YOU/HAVE YOU EVER HAD HEPATITIS
- ULCER
- PAINFUL BOWEL MOVEMENTS
- ABDOMINAL PAIN

NAME:

____

DOB:

____

ENDOCRINE:
- DIABETIC
- THYROID DISEASE
- EXCESSIVE THIRST
- EXCESSIVE URINATION
- HEAT INTOLERANCE
- COLD INTOLERANCE
- HORMONE PROBLEM

PSYCHIATRIC:
- MEMORY LOSS
- CONFUSION
- NERVOUSNESS
- DEPRESSION
- DIFFICULTY SLEEPING

RESPIRATORY:
- FREQUENT COUGH
- SHORTNESS OF BREATH
- SNORING
- SLEEP APNEA
- If yes do you use a CPAP?_______________
- SPITTING UP BLOOD
- WHEEZING
- ASTHMA
- OXYGEN USE

MUSCULOSKELETAL:
- JOINT PAIN
- JOINT SWELLING
- WEAKNESS IN MUSCLES
- MUSCLE CRAMPS
- MUSCLE PAIN
- BACK PAIN
- DIFFICULTY WALKING
- NSAID USE

NEUROLOGICAL:
- NUMBNESS
- TINGLING
- FREQUENT HEADACHES
- LIGHTHEADED
- DIZZINESS
- CONVULSIONS
- TREMBLING
- PARALYSIS
- SEIZURES
- STROKE
- HEAD INJURY

NEW PATIENTS - REVIEW OF SYSTEMS

CHECK ALL THAT APPLY TO YOU

GENITOURINARY:

- URINARY INCONTINENCE
- FREQUENT URINATION
- BURNING/PAINFUL URINATION
- AWAKEN AT NIGHT TO URINATE
- CHANGE IN URINE STREAM FORCE
- BLOOD IN URINE
- DRIBBLING
- KIDNEY STONES
- SEXUAL DIFFICULTY

MALES ONLY:

- TESTICLE LUMPS
- TESTICLE PAIN

FEMALE ONLY:

- PAINFUL PERIODS
- IRREGULAR PERIODS
- VAGINAL DISCHARGE
- Date of last mammogram?___________________
- Date of last pap smear?_____________________
- Number of pregnancies? _____________________
- Number of miscarriages?____________________

Health maintenance

- PNEUMONIA VACCINE
- if yes, date: _______________
- INFLUENZA VACCINE
- if yes, date last given: _______________

HEMATOLOGY:

- ANEMIA
- BLEEDING TENDENCY
- BRUISING TENDENCY
- BLOOD CLOT
- TRANSFUSIONS
- SLOW TO HEAL AFTER CUTS
- CANCER
- If yes what type? ______________________

EYES:

- WEAR GLASSES
- WEAR CONTACT LENSES
- BLURRED VISION
- DOUBLE VISION
- GLAUCOMA
- CATARACTS
- EYE DISEASE

NOSE/THROAT:

- HEARING LOSS
- RINGING IN THE EARS
- EARACHES
- EAR DRAINAGE
- CHRONIC SINUS PROBLEMS
- NOSE BLEEDS
- MOUTH SORES
- SORE THROAT
- HOARSENESS
- SWOLLEN GLANDS IN NECK

NAME:

____

DOB:

____

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:

Allergies:

Injuries & Year of Injury:

FAMILY HISTORY CONT.:

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

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	

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?	

List All Medications You are Now Taking:

Med Name	Dosage	time's daily
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.3		

03/11

INITIALLY REVIEWED BY DR. ______________________ ***Date:*** ______________

MIDWEST NEPHROLOGY CONSULTANTS, P.A. PATIENT REGISTRATION

Patient Biographical Information (Leave no section blank-If not applicable, write N/A)

Name: Last: ______ **First:** ______ **Middle Int:** ______

Date of Birth: ______ **Social Security Number:** ______ ☐ **Male**/☐ **Female**

Phone: Home: ______ **Cell:** ______ **Work:** ______

Address: ______
City State Zip

Email Address: ______

Primary Physician: ______ **Referring Physician:** ______

Required by Federal Law	
Race Check one ☐ 1- Asian ☐ 2- Black African American ☐ 3- White ☐ 5- American Indian/ Alaskan Native ☐ 10- Pacific Islander ☐ 11- More than one race ☐ 12- Native Hawaiian ☐ 13- Refused to report ☐ 14- Undefined	Marital Status ☐ 1-Single ☐ 2-Married ☐ 3-Unknown ☐ 4- Widowed ☐ 5- Divorced ☐ 6- Separated
Ethnicity ☐ Hispanic or Latino ☐ Non-Hispanic or Latino ☐ Refused to report or Unreported ☐ Undefined	Language ☐ English ☐ Spanish ☐ Other______

Emergency Contact Information:

Name: ______ Relationship: ______

Phone Number: ______ Cell: ______

Will you allow us to leave pertinent information with this person? Yes / No

Primary Insurance Information:

Insurance Company Name: ______

Policy Number: ______ Group Number: ______

***Policy Holder / Subscriber*:** ______ Date of Birth: ______

Relationship to Subscriber ☐ Self ☐ Husband ☐ Wife ☐ Son ☐ Daughter ☐ Other

SSN ______

Employer Name ______ Employed: Yes / No / Retired

Employer Number: ______

Secondary Insurance Information:

Insurance Company Name: ______

Policy Number: ______ Group Number: ______

Policy Holder / Subscriber: ______ Date of Birth: ______

Relationship to Subscriber ☐ Self ☐ Husband ☐ Wife ☐ Son ☐ Daughter ☐ Other

SSN ______

Employer Name ______ Employed: Yes / No / Retired

Employer Number: ______

Date: ______ Account #: ______

Authorization & Assignment

Please read carefully

I hereby authorize Midwest Nephrology Consultants, P.A. and 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/surgical services rendered to me or my dependents.
I understand that I am financially responsible for all services rendered which are not covered by my insurance.
I also understand that if I elect to visit a specialist and receive specialty services without a valid 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:______________________

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 giving out this information, however; please be advised the billing staff of Midwest Nephrology Consultants, P.A. will only make one attempt at filing the claim without this pertinent information. If it is declined, the billing department will not pursue collection through the insurance company any further. The claim will be directly turned over to patient responsibility and prompt payment will be expected.

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

Signature:____ Date:______________________

Disclosure of, Presentation, & Scanning of Driver’s License or State ID

Please read carefully

In order to help prevent fraudulent use of your insurance card, Midwest Nephrology Consultants, P.A., requests permission to view, scan and copy your driver’s license or State ID.
You have the right to refuse having your driver’s license scanned or copied.
At each visit please have your driver’s license or State ID available for verification or identity.

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

Signature:____ Date:______________________

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) compliance guidelines.

Prohibition of Video Recording During Office Visits

Please read carefully

We value your privacy. For your protection and possible unauthorized dissemination and interpretations, we ask that you do not video record your visit. Thank you.

Signature:____ Date:______________________

Date:____________________

Account#: ________________