



NEW PATIENT PROFILE

PATIENT NAME: _____ Date of Birth: _____

Sex: Male Female Undefined First _____ MI _____ Last _____
Soc Sec #: _____

Preferred Language: _____ Race: _____

Ethnicity: Not Hispanic or Latino Hispanic or Latino Patient Declined

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ (preferred) Home Mobile Work

_____ (alternate) Home Mobile Work

Email: _____

Emergency Contact: _____ Phone #: _____

Emergency Contact Relationship to Patient: _____

Employed: Yes No Patient's Employer: _____

Employer Address: _____ Work #: _____

Referring Physician: _____

Primary Care: _____

GUARANTOR INFORMATION: Same as Patient (skip this section)

Guarantor's Name: _____ Date of Birth: _____

Sex: Male Female Undefined First _____ MI _____ Last _____
Patient's Relationship to Guarantor: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ (preferred) Home Mobile Work

_____ (alternate) Home Mobile Work

Email: _____

INSURANCE INFORMATION: PRIMARY

Patient's Name: _____

Insured Person Information: Same as Patient (complete Insurance Carrier/Policy #/Group #)

Insurance Company: _____

ID #: _____ Group #: _____

IF POLICY HOLDER IS DIFFERENT FROM PATIENT:

Insured Person Info: _____ Date of Birth: _____
First MI Last

Sex: Male Female Undefined Soc Sec #: _____

Office Use ONLY

Date Verified: _____ Verified by: _____

Effective Date: _____

INSURANCE INFORMATION: SECONDARY

Insured Person Information: Same as Patient (complete Insurance Carrier/Policy #/Group #)

Insurance Company: _____

ID #: _____ Group #: _____

IF POLICY HOLDER IS DIFFERENT FROM PATIENT:

Insured Person Info: _____ Date of Birth: _____
First MI Last

Sex: Male Female Undefined Soc Sec #: _____

Office Use ONLY

Date Verified: _____ Verified by: _____

Effective Date: _____

I authorize North Carolina Nephrology, P.A., to file claims to my insurance company on my behalf for services rendered by providers of North Carolina Nephrology, P.A.

Patient Signature: _____ Date: _____



MEDICAL HISTORY (Confidential)

Patient's Name: First MI Last

Date of Birth: Soc Sec #:

What is the reason for your visit?

Please check if you have ever had any of the following. Use the space to provide details and/or year of onset.

KIDNEY DISEASE

CKD: Stage 1 Stage 2 Stage 3 Stage 4 Stage 5 Unknown

Transplant: Year:

Type: Cadaveric Living Related Living Unrelated

Dialysis: Year: Type: Hemodialysis Peritoneal Dialysis

Polycystic kidney disease

Acute kidney injury Details:

Glomerulonephritis

DIABETES

Diabetes Type 1 Diabetes Type 2 Diabetes Type Unknown

HIGH BLOOD PRESSURE

Essential Renovascular White Coat Conn's Syndrome

ISCHEMIC HEART DISEASE

Heart Attack Yr: Angina Angioplasty: Yr: Coronary Stent Yr: CABG Yr:

STROKE Yr:

GOUT

CANCER

Lung Breast Prostate Colon Melanoma Bladder Other: Lymphoma Kidney Thyroid Leukemia Endometrial Pancreatic

ENT

Blindness Cataracts Hearing Problems Glaucoma

CARDIOVASCULAR

Atrial fibrillation Pacemaker High cholesterol AICD Valvular heart disease Congestive heart disease Mitral valve prolapse

Patient Name: _____

Date of Birth: _____

MEDICAL HISTORY - CONTINUED (CONFIDENTIAL)

RESPIRATORY

- COPD
- Chronic bronchitis
- Asthma
- Emphysema
- Pneumonia
- Tuberculosis
- Sleep apnea

GASTROINTESTINAL

- GERD (gastric reflux)
- Stomach/bowel ulcers
- Gall bladder disease
- Hepatitis
- Inflammatory bowel disease
- Irritable bowel syndrome
- Gluten intolerance
- Lactose intolerance

GENITOURINARY

- Enlarged prostate
- Kidney stones
- Frequent UTIs

OB HISTORY

- Preeclampsia
- Pregnancy induced hypertension
- Gestational diabetes
- History of complicated pregnancy

MUSCULOSKELETAL

- Osteoarthritis
- Osteoporosis

NEUROLOGIC

- Multiple sclerosis
- Seizures
- Parkinson's
- Dementia

PSYCHIATRIC

- Depression
- Anxiety disorder

ENDOCRINE

- Hypothyroidism
- Hyperthyroidism
- Hyperparathyroidism
- Adrenal insufficiency

HEMATOLOGY

- Anemia
- Sickle cell disease
- Sickle cell trait
- Blood transfusion
- Thalassemia

IMMUNO/ALLERGY

- HIV
- AIDS
- Rheumatoid arthritis
- Lupus

SURGICAL HISTORY

- Appendectomy Year: _____
- CABG Year: _____
- Carotid endarterectomy Year: _____
- Cataract surgery Year: _____
- D & C Year: _____
- Gall bladder removal Year: _____
- Gastric bypass Year: _____
- Hemorrhoidectomy Year: _____
- Hernia repair Year: _____
- Hip replacement Year: _____
 - Left Right Bilateral
- Knee replacement Year: _____
 - Left Right Bilateral
- Hysterectomy Year: _____
- Prostatectomy Year: _____
- Nephrectomy Year: _____
- Renal transplant Year: _____
- Thyroidectomy Year: _____
- Tonsillectomy Year: _____
- Valve replacement Year: _____
- AV fistula Year: _____
- AV graft Year: _____
- PD Catheter Year: _____
- Other: _____

Patient Name: _____

Date of Birth: _____

FAMILY HISTORY

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

- | | | | | |
|--|---------------------------------|---------------------------------|----------------------------------|--------------------------------|
| Kidney Disease | <input type="checkbox"/> Father | <input type="checkbox"/> Mother | <input type="checkbox"/> Sibling | <input type="checkbox"/> Child |
| Diabetes | <input type="checkbox"/> Father | <input type="checkbox"/> Mother | <input type="checkbox"/> Sibling | <input type="checkbox"/> Child |
| High Blood Pressure | <input type="checkbox"/> Father | <input type="checkbox"/> Mother | <input type="checkbox"/> Sibling | <input type="checkbox"/> Child |
| Ischemic Heart Disease | <input type="checkbox"/> Father | <input type="checkbox"/> Mother | <input type="checkbox"/> Sibling | <input type="checkbox"/> Child |
| Cancer | <input type="checkbox"/> Father | <input type="checkbox"/> Mother | <input type="checkbox"/> Sibling | <input type="checkbox"/> Child |
| Stroke | <input type="checkbox"/> Father | <input type="checkbox"/> Mother | <input type="checkbox"/> Sibling | <input type="checkbox"/> Child |
| Gout | <input type="checkbox"/> Father | <input type="checkbox"/> Mother | <input type="checkbox"/> Sibling | <input type="checkbox"/> Child |
| Adult Polycystic Kidney Disease | <input type="checkbox"/> Father | <input type="checkbox"/> Mother | <input type="checkbox"/> Sibling | <input type="checkbox"/> Child |
| Dementia | <input type="checkbox"/> Father | <input type="checkbox"/> Mother | <input type="checkbox"/> Sibling | <input type="checkbox"/> Child |

FAMILY HISTORY – STATUS

- Father:** Living Age at death: _____ Cause of Death: _____
 Deceased
 Unknown
- Mother:** Living Age at death: _____ Cause of Death: _____
 Deceased
 Unknown

Other Family History not listed above:

Patient Name: _____

Date of Birth: _____

SOCIAL HISTORY

Current Marital Status: Married Single Divorced Separated Widowed

Living Arrangement: Alone Spouse Significant Other Family member

In home caregiver Assisted living facility

Occupation: Retired Employed Student Unemployed

Current/former occupation: _____

Functional/Cognitive: No impairment Memory deficit
 Hearing loss Poor vision or blindness
 Limited mobility Transportation challenges

SOCIAL HISTORY – HABITS

Tobacco use : Never used Current user Former user Unknown

Cigarettes Chewing tobacco Pipes Snuff Cigars

If a former user, what year did you quit? _____

If a current/former smoker, how often do/did you smoke?

Every day Some days Unknown

How many packs per day do/did you smoke? _____ packs per day

How many total years have you smoked? _____ Years

Alcohol Use: Never used Current user Former user

Occasional social drink 1-2 drinks per day 3 or more drinks per day

If a former user, what year did you quit? _____

Recreational Drug Use: Never used Current user Former user: Year quit: _____

Marijuana Heroin Cocaine Amphetamines

Ecstasy Barbiturates LSD Opium

Other _____

Other Social History not listed above: _____

Patient Name: _____

Date of Birth: _____

REVIEW OF SYSTEMS

Constitutional

- Fever
- Weight gain
- Weight loss
- Fatigue
- Chills
- Weakness

HEENT

- Vision impaired
- Eye pain
- Redness
- Color blindness
- Double vision
- Hearing loss
- Ear pain
- Sinus problems
- Sore throat
- Nose bleeds
- Headache
- Hoarseness
- Tinnitus
- Vertigo

Respiratory

- Shortness of breath
- Shortness of breath at rest
- Shortness of breath with activity
- Pain with breathing
- Cough
- Wheezing
- Blood in sputum
- Night sweats

Cardiovascular

- Chest pain
- Palpitations
- Claudication
- Orthopnea
- Edema
- PND

Gastrointestinal

- Abdominal pain
- Nausea
- Diarrhea
- Heartburn
- Vomiting
- Constipation
- Anorexia
- Trouble swallowing
- Indigestion

Genitourinary

- Urinary urgency
- Urinary burning or pain
- Blood in urine
- Urinary frequency
- Urinary hesitancy
- Foamy urine
- Incontinence
- Nocturia

Musculoskeletal

- Back pain
- Arm weakness
- Muscle pain
- Leg weakness
- Neck pain
- Joint pain

Skin

- Rash
- Itching
- Scaling
- Dryness
- Color change

Neurologic

- Numbness
- Tremors
- Seizures
- Tingling
- Fainting

Psychiatric

- Depression
- Insomnia
- Anxiety

Endocrine

- Heat intolerance
- Cold intolerance
- Excessive thirst
- Excessive urination

Hematology

- Bleeding gums
- Easy bruising

Immuno/Allergy

- Seasonal allergies
- Hives

AUTHORIZATION TO DISCLOSE HEALTHCARE INFORMATION

Patient's Name: _____
First MI Last

Date of Birth: _____ Soc Sec #: _____

Authorized Individual/Organizations:

[Name: _____ Relationship: _____
Address: _____ Phone: _____

[Name: _____ Relationship: _____
Address: _____ Phone: _____

[Name: _____ Relationship: _____
Address: _____ Phone: _____

This request and authorization applies to: All healthcare information.

Healthcare information relating to the following treatment, condition, or dates: _____

Other: _____

Definition: I understand that authorizing the disclosure of this health information is voluntary. I can revoke this authorization at any time. To revoke, I must do so in writing. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the information in my health records may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS) or HIV. It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

Patient Signature

Date



AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____

First MI Last

Date of Birth: _____ Soc Sec #: _____

Physician Office Information:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

This request and authorization applies to:

- All healthcare information.
- Healthcare information relating to the following treatment, conditions, or dates: _____

Other: _____

Definition: Sexually transmitted diseases (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereum, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

Yes No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

Yes No I authorize the release of my records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature

Date

Dr. Michael Casey, Dr. Jason Eckel, Dr. William Fan, Dr. James Godwin, Dr. Karn Gupta, Dr. Jeffrey Hoggard,
Dr. Racquel Holmes, Dr. So Yoon Jang, Dr. Fred Jones, Dr. Dan Koenig, Dr. Kevin Lee, Dr. Sammy Moghazi,
Dr. Michael Monahan, Dr. Romita Mukerjee, Dr. Michael Oliverio, Dr. Robert Olivo, Dr. Sejan Patel, Dr. Eric Raasch,
Dr. Mark Rothman, Dr. Samsheer Sonawane, Dr. Adam Stern, Dr. Phillip Timmons