NORTH CAROLINA NEPHROLOGY, P.A.

1-877-NCN-NCN9 (1-877-626-6269)

NEW PATIENT PROFILE

PATIENT NAME: _____ Date of Birth: _____
First MI Last

Sex: □ Male □ Female □ Undefined 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: _____
First MI Last

Sex: □ Male □ Female □ Undefined 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: _____

NORTH CAROLINA NEPHROLOGY, P.A.

1-877-NCN-NCN9 (1-877-626-6269)

MEDICAL HISTORY
(Confidential)

Patient's Name: _____
First MI Last

Date of Birth: _____ Soc Sec #: _____

What is the reason for your visit? _____

Please √ 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 _____ □ Lymphoma _____
□ Breast _____ □ Kidney _____
□ Prostate _____ □ Thyroid _____
□ Colon _____ □ Leukemia _____
□ Melanoma _____ □ Endometrial _____
□ Bladder _____ □ Pancreatic _____
□ Other: _____

ENT

□ Blindness
□ Cataracts
□ Hearing Problems
□ Glaucoma

CARDIOVASCULAR

□ Atrial fibrillation □ AICD
□ Pacemaker □ Valvular heart disease
□ High cholesterol □ 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

HEMATOLOGY

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

GASTROINTESTINAL

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

IMMUNO/ALLERGY

- □ HIV
- □ AIDS
- □ Rheumatoid arthritis
- □ Lupus

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

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	□ 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
Adult Polycystic Kidney Disease	□ Father	□ Mother	□ Sibling	□ Child
Dementia	□ Father	□ Mother	□ Sibling	□ Child

FAMILY HISTORY – STATUS

Father: □ Living □ Deceased □ Unknown Age at death: _____ Cause of Death: _____

Mother: □ Living □ Deceased □ Unknown Age at death: _____ Cause of Death: _____

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: _____

Funcational/Cognitive:
□ No impairment
□ Hearing loss
□ Limited mobility
□ Memory deficit
□ Poor vision or blindness
□ 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
□ Ectasy □ 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

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MEDICATION LIST

Patient Name:_____
DOB: _____

Please list all medications prescribed by a physician, over-the-counter, and supplements (Examples: Aspirin, vitamins, fish oil, etc).

NAME OF MEDICATION	STRENGTH	DIRECTIONS FOR TAKING THIS MEDICATION	ARE YOU TAKING IT AS DIRECTED Y/N

ALLERGY LIST

NAME OF MEDICATION	REACTION	DATE OF ONSET

NCN | NORTH CAROLINA NEPHROLOGY, P.A.

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient's Name: _____
First MI Last

Date of Birth: _____ Soc Sec #: _____

I have been given a copy of the North Carolina Nephrology, P.A., "Notice of Privacy Practices". I consent to the uses and disclosures of my health information as outlined in the Notice.

_____ _____
Signature of Patient or Representative Date

_____
Print Name

_____
Relationship of Representative to Patient

Please describe the Representative's authority to act on behalf of Patient: _____

_____

_____

For North Carolina Nephrology use ONLY

If acknowledgement of receipt of the Notice of Privacy Practices is not obtained from the patient or the patient's representative, please explain your efforts to obtain acknowledgement and the reason you could not obtain it:

_____

_____

_____

_____

_____

NCN | NORTH CAROLINA NEPHROLOGY, P.A.

1-877-NCN-NCN9 (1-877-626-6269)

FINANCIAL ARRANGEMENTS AND INSURANCE

You will find that our fees for specialized care are comparable to other Nephrologists in this area. If you have medical insurance to cover your expenses, we will, as a courtesy to you, file your insurance. We want to help you receive your maximum allowable benefits, and in order to achieve these goals, we will need your assistance and your understanding of our payment policy.

If you do not have medical insurance, you are expected to pay for services incurred at the time of service. We realize that individual financial situations may affect timely payment of your account. If this is the case, you will be asked to talk to one of our account representatives to set up a regular payment plan for services incurred.

We will make every effort to maximize your insurance benefits, but you must understand the following:

1) Your insurance coverage is a contract between you and the insurance company. We are not a part of that contract.
2) Insurance companies often judge a fee as "usual and customary" (UCR). As a specialist in Nephrology our fees are grouped in with other nephrologists for UCR calculation. Therefore, some of our fees may be slightly higher than the UCR because of the severity of different problems with individual patients.
3) Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.

We must emphasize that our relationship is with you as a patient, not with your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered.

If you have any questions about the above information or any uncertainty regarding insurance coverage, please don't hesitate to ask our staff. We are here to help you.

This is to certify that I, the undersigned, agree to accept full responsibility for the payment of all fees and that I have read, understand, and agree to the financial arrangements stated above.

Patient/Responsible Party Signature	Date
Printed Name	Chart #

NCN | NORTH CAROLINA NEPHROLOGY, P.A.

1-877-NCN-NCN9 (1-877-626-6269)

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

NORTH CAROLINA NEPHROLOGY, P.A.

1-877-NCN-NCN9 (1-877-626-6269)

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 venereuem, 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