CLEAR FORM

Nephrology Associates Patient Registration

Last Name _____ First Name _____ Middle Initial _____

Social Security Number _____ Date of Birth _____

Gender _____ Marital Status: ◯ Married ◯ Single ◯ Widow(er) ◯ Divorced

Address _____ City/State/Zip _____

Preferred Type of Automated Appointment Reminder ◯ Voice ◯ Text ◯ Email _____

Cell Phone _____ Leave Message ◯ Yes ◯ No

Home Phone _____ Leave Message ◯ Yes ◯ No

Email _____

Are You Disabled: ◯ Yes ◯ No

Employer _____ Occupation _____

Pharmacy _____ Phone _____ Lab _____

Primary Physician _____

Referring Physician _____

INSURANCE

Is your Insurance in another family member's name? If so enter Name of Subscriber _____

Primary Insurance Name _____ ID Number _____

Secondary Insurance Name _____ ID Number _____

Emergency Contacts / Release of Medical, Billing & Appointment Information

I authorize Nephrology Associates M.D.,P.A to discuss my medical, billing, and appointment information with the following individuals:

My Spouse--Name _____ PH: _____

☐ Do Not discuss billing

Name _____ Relation: _____ PH: _____

☐ Do not discuss billing

Name _____ Relation: _____ PH: _____

☐ Do not discuss billing

Patient Signature _____ Date _____

Revised 12/17/19

NEPHROLOGY ASSOCIATES, M.D., P.A.

DATE_____

PATIENT NAME_____ **DATE OF BIRTH**_____ **AGE**_____

REFERRED BY_____ **INSURANCE**_____

BRIEFLY STATE CURRENT PROBLEM_____

_____

_____

HISTORY PRESENT ILLNESS (Leave blank)_____

_____

_____

_____

_____

MEDICATIONS YOU ARE PRESENTLY TAKING (INCLUDE LAXATIVES AND VITAMINS)

Name	Strength of Pills (mg)	Pills per Dose	Times per day
Ex: Hydralazine	*50 mg*	*1½*	*3 times a day*
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

ALLERGIES:_____

List problems that a physician has treated you for:
(high blood pressure, stroke, diabetes, high cholesterol, other)

_____

Have you had a blood transfusion?_____ If yes, when _____

List all surgeries

Operation	Date	Physician	Hospital

List Hospitalizations

Illness	Date	Physician	Hospital

FAMILY HISTORY

	Living	Age	Present Diseases	Deceased	Age	Cause of death
Father						
Mother						
Brothers						
Sisters						
Sons						
Daughters						

Do any other blood relatives have the following problems?

	Relative		
Heart disease	_____	Cancer (type)	_____
High Blood Pressure	_____	TB	_____
Kidney disease	_____	Diabetes	_____
Thyroid disease	_____	Asthma	_____
Blood disease	_____		

SOCIAL HISTORY

Marital status M S D W

Occupation_____

Cups of coffee/day_____ Amount of alcoholic beverages/day_____

Recreational drugs used, past or present_____

Have you ever smoked regularly?_____

Packs of cigarettes/day_____ For how long_____ If quit, when_____

Weight five years ago_____ Exercise program_____ Diet_____

REVIEW OF SYSTEMS

Do you often have? Please check each line

No	Yes (Frequency)	
_____	_____	Headaches
_____	_____	Decreased vision
_____	_____	Decreased hearing
_____	_____	Nose bleeding
_____	_____	Sinus trouble
_____	_____	Trouble swallowing
_____	_____	Dry cough
_____	_____	Productive cough
_____	_____	Coughing up blood
_____	_____	Shortness of breath on exercise
_____	_____	Lung disease
_____	_____	Shortness of breath lying down
_____	_____	Shortness of breath waking you up
_____	_____	Chest pain on exercise
_____	_____	Ankle swelling
_____	_____	Heart murmurs
_____	_____	Pain in legs with exercise
_____	_____	Infections in kidneys or bladder
_____	_____	Blood in urine
_____	_____	Kidney stones
_____	_____	Burning on urination
_____	_____	Trouble starting urine
_____	_____	Trouble holding urine
_____	_____	Need to urinate at night (number of times _____)
_____	_____	Kidney x-ray
_____	_____	Prostate enlargement
_____	_____	Erectile dysfunction
_____	_____	Constipation
_____	_____	Diarrhea
_____	_____	Nausea
_____	_____	Vomiting
_____	_____	Vomiting blood
_____	_____	Rectal bleeding
_____	_____	Ulcers

Do you often have? (please check each line)

No	Yes (Frequency)	
_____	_____	Back pain
_____	_____	Arthritis (which joints:_____)
_____	_____	Gout
_____	_____	Dizziness
_____	_____	Nervousness
_____	_____	Trouble with balance
_____	_____	Neuropathy (numbness or uncomfortable sensation in feet/hands)