Nephrology Associates of Sarasota

Registration Form (Please Print)

First Name: _____ **MI:** _____ **Last Name:** _____

Mailing Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Date of Birth: ____/____/_____ **Social Security #:** ____-____-_____ **Gender (circle one):** Male or Female

Home Number: (____) _____-_____
___ OK to leave message with detailed information
___ Leave message with call back numbers only

Work Number: (____) _____-_____
____OK to leave message with detailed information
____ Leave message with call back numbers only

Cell Phone: (____) _____-_____
___ OK to leave message with detailed information
___ Leave message with call back numbers only

Race: _____ **Ethnicity:** _____ **Preferred 1st Language:** _____

Marital Status (circle one): Single/Married/Widowed **Employed (circle one)** None/Retired/Full-time/Part-time

Emergency Contact Name: _____

Phone #: _____ **Relationship:** _____

Primary Insurance
Name: _____

Insured Name: _____

Insurance Plan ID#
_____

Insurance Plan Group
#_____
If available

Secondary Ins.
Name: _____

Insured Name: _____

Insurance Plan ID# _____

Insurance Plan Group#
_____
If available

Are you the sponsor of the above insurance? YES / NO
If not, please provide the following:
Spouse/Parent Name: _____

Date of Birth: _____/_____/_____

Are you the sponsor of the above insurance? YES / NO
If not, please provide the following:
Spouse/Parent Name: _____

Date of Birth: _____/_____/_____

*Co-pays and balances are due at the time of service. We will bill only two contracted insurance companies; however, you are ultimately responsible for all charges whether the insurance company paid for your claim or not. We accept checks, cash, and most credit cards. I hereby authorize Nephrology Associates of Sarasota and staff to disclose my individually identifiable health information to the insurance carrier(s) to disclose my health information to obtain payment to the doctor for services rendered and allow insurance companies to process claims. I understand that this authorization is voluntary.

Patient, Guardian and/or Insured Signature: _____ **Date:** _____

Nephrology Associates of Sarasota

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly. o Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

(Please look on clip board or in binder for copy of HIPAA)

On occasion, it may be necessary to release clinical information to outside physicians, that you have been referred to to aide in your coordination of care. We will not release your Information to any third parties.

Designation of Certain Relatives, Close Friends and other Caregivers as my Personal Representative:

I agree that the practice may disclose certain pieces of my health information to a Personal Representative of my choosing, since such person is involved with my healthcare or payment relating to my healthcare. In that case, the Physician Practice will disclose only information that is directly relevant to the person's involvement with my healthcare or payment relating to my health care.

Print Name: _____ DO.B._____

Print Name: _____ D.O.B._____

Print Name: _____ D.O.B._____

The following person(s) **are not authorized** to receive my Patient Health Information (PHI):

Print Name: _____ Print Name: _____

Print Name: _____ Print Name: _____

_____ _____

Patient Name

_____

Relationship to patient (if not self)

Nephrology Associates of Sarasota (History Form)

Patient Name: _____ **Height:** _____ **Weight:** _____
Please Print

Do you have diabetes? YES or NO **If yes:** TYPE I or Type II **Controlled By:** Insulin/Oral Medication/Diet

Do you have high blood pressure? YES or NO **If yes how many years**_____

Current Medical Conditions or Past Illnesses: _____

_____

_____

Past surgeries: _____

_____

Have you ever had a Blood Transfusion? YES or NO If Yes, DATE _____

Please list Past and Present Urinary/Kidney Problems _____

_____

_____

Do you have any Shortness of Breath? _____

MEDICATIONS THAT YOU ARE TAKING: _____ _____
INCLUDE DOSAGE

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

PLEASE LIST ANY OVER THE COUNTER MEDICINE / VITAMINS YOU TAKE _____

_____ _____ _____

Date of Last Influenza Vaccine _____ **Date of Last Pneumococcal Vaccine**_____

Are you allergic to any medications? Please list: _____

Are you allergic to latex, adhesive, iodine, etc.? Please list: _____

Family Medical History

Is your biological father LIVING or DECEASED? How did your father pass away? _____

Is your biological mother LIVING or DECEASED? How did your mother pass away? _____

Did/Does your biological father have: DIABETES / HEART DISEASE / CANCER / HYPERTENSION?

Did/Does your biological mother have: DIABETES / HEART DISEASE / CANCER / HYPERTENSION?

Did/Does your brothers or sisters have: DIABETES / HEART DIESASE / CANCER / HYPERTENSION?

How many: Brothers_____Sisters_____Sons_____Daughter_____

Social History

Do you currently smoke? YES or NO If yes, how many per day? _____

If no, have you ever smoked in the past, YES or NO How many years has it been since you quit? _____

Do you drink alcohol? YES or NO

If yes, how much do you consume? 1-2 PER DAY / 2 OR MORE PER DAY / 1-2 PER WEEK / MONTHLY / COUPLE TIME A YEAR

Do you drink coffee/caffeine every day? YES or NO How many cups per day_____

Primary Care Physician (first and last name): _____ **Phone:** _____

Preferred lab to send orders to: LABCORP QUEST SARASOTA MEMORIAL Other_____
(Please circle one)

Preferred Pharmacy _____ **Ph#**_____

Pharmacy Address _____

Signature: _____ **Date:** _____

Print Name _____