KidneyCare OKLAHOMA
Nephrology Associates, Inc.

NEW PATIENT INFORMATION

DEMOGRAPHICS -

NAME:_____ **DATE OF BIRTH:**_____

SOCIAL SECURITY NUMBER:_____ **MARITAL STATUS:**_____
(SSN NEEDED FOR INSURANCE PURPOSES)

SEX: MALE FEMALE OTHER **ETHNICITY/RACE:**_____

MAILING ADDRESS:_____

EMAIL:_____ **HOME PHONE:**_____

CELL PHONE:_____ **WORK PHONE:**_____

PRIMARY CARE DOCTOR:_____ **PHONE NUMBER:**_____

INSURANCE INFORMATION - Primary

Type:_____

MEMBER ID:_____

Group Number _____

Effective Date _____

Subscriber (If other than patient):_____

Subscriber Date of Birth:_____

Relationship to Patient:_____

Subscriber Social Security # ***(Insurance Purposes)***

_____

INSURANCE INFORMATION - Secondary

Type:_____

MEMBER ID:_____

Group Number _____

Effective Date _____

Subscriber (If other than patient):_____

Subscriber Date of Birth:_____

Relationship to Patient:_____

Subscriber Social Security # ***(Insurance Purposes)***

_____

EMERGENCY CONTACT INFO –

NAME:_____ **RELATIONSHIP:**_____
Phone number _____

All professional services rendered are charged to the patient's account. Necessary forms will be completed to expedite insurance claims for those plans which the physician files. The patient is responsible for all fees, regardless of insurance coverages.

I hereby assign to the physician all payments for medical services rendered and authorize the physician to release any medical information necessary to process claims and request payments from insurance companies or Medicaid payers. A photocopy of this assignment and authorization shall be considered as valid as the original.

SIGNATURE:_____ **DATE:**_____

KidneyCare OKLAHOMA
Nephrology Associates, Inc.

2000 S Wheeling Ave, Suite 510
Tulsa, OK 74104
Ph: 918.747.5200
Fax: 918.858.0290

3369 W Broadway,
Muskogee, OK 74401
Ph: 918.747.5200 opt 2
Fax: 918.858.0290

3500 State St,
Bartlesville, OK 74006
Ph: 918.331.1130
Fax: 918.331.123

VERBAL DISCLOSURE OF PROTECTED HEALTH INFORMATION TO INDIVIDUALS INVOLVED IN PATIENT CARE

PATIENT NAME _____

DATE OF BIRTH _____

In accordance with the provisions of Section 164.51o(b) of the Health Insurance Portability and Accountability Act (HIP AA), I agree that any healthcare provider of the KidneyCare Oklahoma and its' duly authorized agents and employees may disclose Protected Health Information directly relevant to relatives, dose personal friends and/or any other individuals that I indicate below who may contact any provider listed above on my behalf.

NAME OF INDIVIDUAL(S) AND RELATIONSHIP (Please Print) Circle the type of information to be disclosed next to name.

Name:_____ **Please Circle:** **Medical** **Billing**

Name:_____ **Please Circle:** **Medical** **Billing**

Name:_____ **Please Circle:** **Medical** **Billing**

I understand:

- At any time, I may add or remove individuals from this list by notifying my provider of my desire to do so. I understand that until I notify my provider of requested changes to this list, my provider may rely on this list and disclose information to the individuals listed above.
- Information disclosed to the individuals identified above may be subject to re-disclosure by the recipient and no longer protected by federal law.

I understand that my medical information may indicate that I have a communicable or venereal disease, which may include, but are not limited to, diseases such as hepatitis, syphilis, gonorrhea, and human immunodeficiency viruses also known as Acquired Immune Deficiency Syndrome (AIDS). I further understand that my medical information may indicate that I have or have been treated for psychological or psychiatric conditions or substance abuse.

Signature of Patient _____ **DATE** _____

Signature of Personal Representative _____ **DATE** _____

Description of Representatives Authority of Act for Patient _____

DATE_____

Notice of Rights: Information in your medical records that you have or may have a communicable or venereal disease is made confidential by law and cannot be disclosed without your permission except in limited circumstances including disclosure to persons who have had risk exposure, disclosure pursuant to an order of the court or the Department of Health, disclosure among healthcare providers or for statistical or epidemiological purposes. When such information is disclosed, it cannot

KidneyCare OKLAHOMA
Nephrology Associates, Inc.

contain information from which you could be identified unless disclosure of that identifying information is authorized by you, by an order of the court or the Department of Health or by law.

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

PATIENT NAME:_____
DATE OF BIRTH:_____ **SOCIAL SECURITY NUMBER:**_____

I hereby authorize the use/disclosure of Protected Health Information about me as described below. I understand that if the person or entity that receives this information is not a health care provider, health plan or health care clearinghouse that must follow the federal privacy standards, the health information disclosed as result of this authorization may be re-disclosed by such person or entity and will likely be protected by the federal standards. The recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality requirements.

Release to (Person/Organization receiving PH1):
KIDNEYCARE OKLAHOMA
2000 SOUTH WHEELING, SUITE 510, TULSA, OK 741
P:918-747-5200 F:918-858-0290

Person/Organization providing information:
_____
_____
_____

Information authorized for use or disclosure or to be obtained:
__All medical information concerning this patient
__Medical information of this patient compiled between _____ to _____

__Entire Chart	**__Consultations**	**__X-Ray Films**	**__Nurse Notes**
__Immunization Record	**__Progress Notes**	**__Imaging Reports**	**__Outpatient Record**
__Discharge Summary	**__Lab Work**	**__Pathology Report**	**__Face Sheets**
__History and Physical	**__EKG/EEG/EMG**	**__Physician Orders**	**__Other (Please List)**
__Demographic Information	**__Emergency Room**		

The information will be obtained, used or disclosed for the following purpose(s) only:

__Further Medical Care	**__Personal**	**__Changing Physicians**	**__Other**
__Insurance Eligibility/Benefits	**__Legal Investigation/Action**	**__Request of Patient/Patient Representative**	

I understand:

- **I may revoke this authorization by notifying the keeper of my medical record in writing at any time, except revocation will not apply to information already used or disclosed in response to this authorization. I may revoke this document by presenting my written revocation as provided in the notice of Privacy Practices. This authorization expires 1 year after the date of the content. If this authorization is for use or disclosure of protected health information for research, the authorization will expire at the end of the research study.**
- **I release The Clinic, its agents and employees from any liability in connection with the use or disclosure of protected health information. The entity authorized to disclose the information will not be compensated by the recipient.**
- **I have the right to inspect the health information to be released.**
- **I may refuse to sign this authorization and the refusal to sign will not affect my ability to obtain treatment or payment or eligibility for benefits.**
- **I understand the information authorized for release may include information which may be considered a communicable or venereal disease which may include but is not limited to diseases such as hepatitis, syphilis, gonorrhea, and the human immunodeficiency virus, also known as Acquired Immune Deficiency Syndrome (AIDS). I further understand that my medical information may indicate that I have been treated for psychological or psychiatric conditions or substance abuse.**

NOTE OF RIGHTS: Information in your medical record that you have or may have a communicable or venereal disease is confidential by law and cannot be disclosed without your permission except in limited circumstances including disclosure to persons who have had risk exposures, disclosure pursuant to an order of the court of the Department of Health, disclosure among health care providers or disclosures for statistical or epidemiological purposes. When such information is disclosed, it cannot contain information for which you could be identified unless disclosure of that identifying information is authorized by you, by an order of the courts of the Department of Health or by law.

Patient Name:_____ **Relationship of Personal Rep to Patient:**_____

Name of Personal Representative of Patient:_____

Signature of Patient or Personal Representative _____ **Date:**_____

KidneyCare OKLAHOMA
Nephrology Associates, Inc.

Please check the medical conditions you have or have had:

☐ AIDS/ HIV positive	☐ Chronic kidney disease	☐ Gout	☐ Pneumonia
☐ Anemia	☐ Congestive Heart Failure	☐ Heart Disease	☐ Prostate Cancer
☐ Anorexia / Bulimia	☐ Coronary Artery Disease	☐ Hepatitis	☐ Rheumatic Fever
☐ Arthritis	☐ Stents or Balloon Angioplasty	☐ Hernia Site? _____	☐ Stroke
☐ Asthma	☐ Diabetes Type?	☐ Hypertension & Duration	☐ Suicide attempt
☐ Bleeding disorders	_____ On Insulin	_____	☐ Tonsillitis
☐ Blood in urine	Yes or No	☐ Hypo or Hyperthyroidism	☐ Tuberculosis
☐ Bronchitis	Duration_____	☐ Kidney Stones	☐ Ulcers & Where?
☐ Cancer (type)	☐ Emphysema	☐ Liver Disease	_____
_____	☐ Enlarged Prostate	☐ Migraine / Headaches	☐ Other _____
☐ Chemical dependency	☐ Epilepsy	☐ Multiple Sclerosis	
	☐ Gallbladder Disease	☐ Pacemaker	
	☐ Goiter		

Past Surgical History:

Type of Surgery	**Year**	**Type of Surgery**	**Year**
Appendectomy		C- Section & number of times	
Colon Surgery		Knee Surgery (Right or Left)	
Cholecystectomy		Hip Surgery (Right or Left)	
CABG……Vessel		Back Surgery	
Kidney Biopsy		Hysterectomy	
Thyroid Surgery			

Have you ever had a blood transfusion? YES or NO If yes, give approximate date: _____

Family History: (Fill in health information about your family.) Please Circle if Adopted

Relative	**Age**	**State of Health**	**Age of Death**	**Cause of Death**
Mother				
Father				
Brother(s)				
Sister(s)				

Check if your Blood Relative had any of the following. (Please indicate who)

☐ Arthritis, Gout _____	☐ Hearty Disease _____	☐ Kidney Disease _____	☐ Thyroid _____
☐ Cancer _____	☐ Strokes _____	☐ Kidney Stones _____	☐ Other _____
☐ Diabetes _____	☐ High Blood Pressure	☐ Tuberculosis _____	☐ Other _____
☐ Dialysis _____	_____	☐ COPD _____	

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his staff responsible for any errors or omissions that I may have made in the completion of this form. I consent to examination/treatment/surgery if indicated by the physicians of Nephrology Associates, Inc.

Signature:_____ Date: _____

KidneyCare
OKLAHOMA
Nephrology Associates, Inc.

Medications List

Allergies:_____

_____

Allergic to Latex? **YES** **NO**

MEDICATION NAME:	DOSAGE(mg):	FREQUENCY (how often):