Georgia Kidney Associates

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Patient Information Sheet

Patient Name: _____ Date of Birth: _____

Height: _____

Referred By: _____

Family History: Have any of your relatives had any of the following diseases? If so, please indicate which relative(s) was (were) affected:

Disease	Family Member
Diabetes	
High Blood Pressure	
Heart Attack	
Other Heart Disease	
Stroke	
Cancer	
Kidney Failure	
Arthritis	
Lupus or Similar Disease	
Deafness	
Bleeding Problems	
Inherited Disease	

Father: Living Yes ( ) Health Status: _____
No ( ) Cause of Death: _____

Mother: Living Yes ( ) Health Status: _____
No ( ) Cause of Death: _____

Brothers: Number Living ( ) Number Deceased ( )

Sisters: Number Living ( ) Number Deceased ( )

Social History:

Marital Staus: Married ( ) Single ( ) Divorced ( ) Widowed ( )

Transfusions: Yes ( ) No ( )
Cigarette Use: Yes ( ) No ( )
Alcohol Use: Yes ( ) No ( )

Recreational Drug Use: Yes ( ) No ( )
Regular Use of Seat Belts: Yes ( ) No ( )

Employment: _____
Spouse's Name: _____
Spouse'sEmployment: _____
Education: _____

Patient Name: _____ Date of Birth: _____

Children:

Daughters	
Sons	

Pharmacy Name:_____
Address:_____
Phone Number:_____

Medications:

Name of Medication:	Dosage	Frequency

Allergies - Reaction

Past Medical History

Surgeries and/or Hospitalizations:

Procedure:	Date	Yes	No
Tonsillectomy			
Hysterectomy			
Gallbladder removed			
Appendectomy			
Heart Surgery			
Others:			

Georgia Kidney Associates

Patient Registration Form

Patient Name: ______________________________ ☐ M/☐ F Date: __/__/__
(First) (MI) (Last) (Sex)

Home Address: ______________________________
(Street / Number) (City) (State) (ZIP)

Home Phone: (   ) – Date of Birth: __/__/__ Age: ____ Marital Status: ____

SSN: __/__/__ Known Allergies: ______________________________

Patient's Employer: ______________________ Phone Number: (   ) -

Address: ______________________________
(Street / Number) (City) (State) (ZIP)

Spouse's or Parent's Name: ______________________ SSN: __/__/__

Spouse's or Parent's Employer: ______________________ Phone Number: (   ) -

Address: ______________________________
(Street / Number) (City) (State) (ZIP)

Next of Kin/Nearest Relative/Friend: ______________________ Phone Number: (   ) -

Address: ______________________________
(Street / Number) (City) (State) (ZIP)

**************************INSURANCE INFORMATION**************************

Medicare Number ______________________ Medicaid Number ______________________

Insurance Company #1 ______________________ Group Name ______________________

Address: ______________________________
(Street / Number) (City) (State) (ZIP)

Insured: ______________________ I.D. Number: __________ Policy Number: __________

Insurance Company #2 ______________________ Group Name ______________________

Address: ______________________________
(Street / Number) (City) (State) (ZIP)

Insured: ______________________ I.D. Number: __________ Policy Number: __________

Referred by: ______________________________

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I authorize any physician, hospital, or clinic to provide full details of my medical history and treatment to Dr. Himot, Dr. Chervu, Dr. Jansen, Dr. Ogundipe, Dr. Nath or Dr. Jaglan. I also authorize Dr. Himot, Dr. Chervu, Dr. Jansen, Dr. Ogundipe, Dr. Nath or Dr. Jaglan to furnish my insurance company any information they may request regarding my present illness or injury.

I hereby assign payment directly to GEORGIA KIDNEY ASSOCIATES, INC. the amount now due for medical expenses incurred and payable under terms of my basic insurance as well as Major Medical benefits. I understand that I am financially responsible for any charges not covered by this assignment. PHOTOCOPIES OF THIS FORM WILL BE VALID.

______________________________ ______________________
Signature of Patient/Parent **(Date)**

GEORGIA KIDNEY ASSOCIATES
PREVENTATIVE HEALTH QUESTIONNAIRE

PATIENT NAME_____ DATE_____

Please indicate the last time you had the following preventative health exams and/or immunizations.

All Patients:

Colonoscopy_____

Sigmoidoscopy_____

Cholesterol Screening_____

If Male:

PSA_____

Prostate Exam_____

Adult Immunizations:

Tetanus_____

Influenza_____

Pneumonia_____

Hepatitis A_____

Hepatitis B_____

If Diabetic:

Vision Screening_____

Podiatry (Foot) Exam_____

Hemoglobin A1C_____

If Female:

Mammogram_____

Breast Exam_____

PAP Smear_____

Childhood Immunizations: (circle yes or no)

Mumps	YES	NO
Measles	YES	NO
Rubella	YES	NO
Chicken Pox	YES	NO

GEORGIA KIDNEY ASSOCIATES, INC.

PATIENT CONFIDENTIALITY FORM

TO ENSURE THAT THERE IS NO VIOLATION OF YOUR PRIVACY, PLEASE PROVIDE US WITH THE FOLLOWING INFORMATION:

In the event that I, _____, cannot be reached, Georgia Kidney Associates, Inc. may leave any test result, lab result, appointment information or other confidential medical information with the following:

Please circle all that apply:

Spouse	Name:	_____	Number:	_____
Children	Name:	_____	Number:	_____
	Name:	_____	Number:	_____
	Name:	_____	Number:	_____
Home Voice Mail:			Number:	_____
Work Voice Mail:			Number:	_____
Cell Voice Mail:			Number:	_____
Other	Name:	_____	Number:	_____
	Name:	_____	Number:	_____

If there is anyone you ***DO NOT*** wish us to discuss this information wish, please specify below.

_____

_____

_____

_____ _____

PATIENT SIGNATURE DATE