

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 () Sisters: Number Living ()
 Number Deceased () Number Deceased ()

Social History:

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

Transfusions: Yes () No () Recreational Drug Use: Yes () No ()

Cigarette Use: Yes () No () Regular Use of Seat Belts: Yes () No ()

Alcohol Use: Yes () No ()

Employment: _____

Spouse's Name: _____

Spouse's Employment: _____

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:			

Patient Name: _____ Date of Birth: _____

REVIEW OF SYSTEMS

Please answer yes or no to each question and provide an explanation of any affirmative answer.

General	Yes	No	Explanation
Change in appetite			
Change in weight			
Anemia			
Bleeding Problem			
History of Cancer			

Endocrine	Yes	No	Explanation
Diabetes			
Thyroid Disease			
Cortisone Use			

ENT	Yes	No	Explanation
Glasses			
Changing vision			
Deafness			
Sinus problems			
Swallowing problem			
Other			

Pulmonary	Yes	No	Explanation
Cigarette Use			
Cough up Blood			
Chronic Cough			
Asthma			
Pneumonia			
Emphysema			
Chronic Bronchitis			
Shortness of Breath			
Other			

Cardiovascular	Yes	No	Explanation
Rheumatic Fever			
Heart Murmur			
Chest Discomfort			
Chest Pain			
Heart Attack			
Irregular Pulse			
Palpitations			
Shortness of Breath			
Swelling			
High Blood Pressure			
Heart Failure			
Fainting			
Blood Clots			

Patient Name: _____ Date of Birth: _____

Cardiovascular	Yes	No	Explanation
Abnormal EKG			
Cardiac Catheter			
Exercise Test			
Other			

Gastrointestinal	Yes	No	Explanation
Hepatitis			
Jaundice			
Blood in Stools			
Nausea/Vomiting			
Ulcers			
Vomiting Blood			
Chronic Diarrhea			
Constipation			
Cancer			
Other			

Renal and GU	Yes	No	Explanation
Kidney Stones			
Bright's Disease			
Blood in Urine			
Protein in Urine			
Kidney Failure			
Voiding Difficulty			
Bladder Surgery			
Bladder Infections			
Kidney Infections			
Prostate Disease			
Other			

Musculoskeletal	Yes	No	Explanation
Joint Pain			
Joint Swelling/Heat			
Deformed Joints			
Broken Bones			
Skin Rash			
Skin Cancer			
Hair Loss/Gain			
Nail Problems			
Other			

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: _____

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 Diabetic:

Vision Screening _____

Podiatry (Foot) Exam _____

Hemoglobin A1C _____

If Male:

PSA _____

Prostate Exam _____

If Female:

Mammogram _____

Breast Exam _____

PAP Smear _____

Adult Immunizations:

Tetanus _____

Influenza _____

Pneumonia _____

Hepatitis A _____

Hepatitis B _____

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 with, please specify below.

PATIENT SIGNATURE

DATE