Georgia Kidney Associates

Edward D. Himot, M.D., Indira Chervu, M.D., F.A.C.P., Robert D. Jansen, M.D., Akin O. Ogundipe, M.D., F.A.C.P.,
Vijay Nath, M.D., Sandeep Jaglan, M.D., Amish Patel, M.D., Kimone James, M.D., Samuel A. Johnson, M.D.

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:			

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			

Patient Name: ______________________________ Date of Birth: ______________

Neurologic	Yes	No	Explanation
Seizures			
Stroke			
Headaches			
Change in Vision			
Dizziness			
Fainting			
Tremor/Shakes			
Trouble Walking			
Psychiatric Problem			
Other			

For Women Only	Yes	No	Explanation
Change in Periods			
Menopause			
Abnormal Bleeding			
Recent Pelvic/Pap			
Gyn Cancer			
Problem Pregnancies			
Toxemia			
Miscarriages			
Breast Masses			
Breast Surgery			
Breast Cancer			
Mammograms			
Gynecologist			

Any further information which you believe is important may be provided in the space below.

PATIENT REGISTRATION FORM

PATIENT'S NAME:____M/F______DATE:______________
(First) (MI) (Last) (Sex)

HOME ADDRESS:________________________________CITY:______________STATE:_____ZIP:__________

HOME PHONE:____________________DATE OF BIRTH:____________AGE:______MARITAL STATUS:__________

SOCIAL SECURITY NUMBER:______________________KNOWN ALLERGIES:___________________________

PATIENT"S EMPLOYER:______________________________________PHONE NUMBER:________________

ADDRESS:___________________________________CITY:______________STATE:______ZIP:__________

SPOUSE'S OR PARENT'S NAME:____________________________SOCIAL SECURITY NUMBER:______________

SPOUSE'S OR PARENT'S EMPLOYER:_____________________________PHONE NUMBER:________________

ADDRESS:___________________________________CITY:______________STATE:______ZIP:__________

NEXT OF KIN/NEAREST RELATIVE OR FRIEND:_______________________PHONE NUMBER:________________

ADDRESS:___________________________________CITY:______________STATE:______ZIP:__________

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

MEDICARE NUMBER: __________________________MEDICAID:_________________________________

INSURANCE COMPANY #1:_______________________________GROUP NAME:_______________________

ADDRESS:___________________________________CITY:______________STATE:______ZIP:__________

INSURED:___________________I.D. NUMBER:______________________POLICY NUMBER:______________

INSURANCE COMPANY #2:_______________________________GROUP NAME:_______________________

ADDRESS:___________________________________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. Ogundipe, Dr. Nath, Dr. Jaglan, Dr. James, or Dr. Johnson. I also authorize Dr. Himot, Dr. Chervu, Dr. Ogundipe, Dr. Nath, Dr. Jaglan, Dr. James, Dr. Johnson or Dr. Suthar to furnish my insurance company any information they request concerning my present illness or injury.

I authorize Georgia Kidney Associates, Edward D. Himot, MD; Indira Chervu, MD; Akin O. Ogundipe, MD; Vijay Nath, MD; Sandeep Jaglan, MD; Kimone James, MD; Samuel A. Johnson, MD; Samantha D. Suthar, MD; Renée Figueroa, ANP-BC; Trang Nguyen, NP-C; ACCNS-AG, NP-C; Alexandra Diluzio, PA-C; Angela Berndt, ACNP-BC; Jessica Brown, NP-C; and any other affiliated professionals to render medical care and treatment to me.

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 INVALID.**

DATE:________________ **SIGNATURE OF PATIENT/PARENT:** ______________________________

GEORGIA KIDNEY ASSOCIATES
PREVENTIVE HEALTH QUESTIONNAIRE

PATIENT NAME:________________________________ DATE:________________

Please indicate the last time you had the following preventive health exams and/or immunizations:

All Patients:
Colonoscopy____________________________
Sigmoidoscopy__________________________
Cholesterol Screening____________________

If Male:
PSA___________________________________
Prostate Exam__________________________

If Diabetic:
Vision Screening________________________
Podiatry (Foot) Exam____________________
Hemoglobin A1C________________________

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
Measels	YES	NO
Rubella	YES	NO
Chicken Pox	YES	NO

Other Physicians:

Name:____________________________ Address:________________________________
____

Name:____________________________ Address:________________________________
____

Name:____________________________ Address:________________________________
____

Name:____________________________ Address:________________________________
____

FORM# GKA4620

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