Name: _____ **DOB:** _____

What was the date of your last FLU Vaccine? _____ **Month/Year if you don't know the exact date**

Medications

Please list any medications you currently taking along with **dosage and directions** (including birth control, vitamins and OTC medications):

☐ **I brought all my bottles with me** ☐ **See attached/below medication list**

_____

_____

_____

_____

Medical History – Health Conditions

CONDITION	Y	N	CONDITION	Y	N	CONDITION	Y	N
Kidney Disease			Kidney Stones			Epilepsy/Seizures		
Irregular Heart Beat			Tuberculosis			Thyroid Problems		
High Blood Pressure			Gallstones			Anemia		
Heart Attack			Liver Disease			Asthma		
Heart Murmur			Ulcers in Stomach/Bowels			Blood Transfusion		
Rheumatic Fever			Bleeding from Bowels			Depression		
High Cholesterol			Arthritis			Anxiety		
Congestive Heart Failure			Prostate Problems			Cancer		
Emphysema/Chronic Bronchitis			Gout			Details:		
Blood Clot in Lung			Skin Disease					
Blood Clot in Leg			Diabetes/High Blood Sugar			Other:		
Bleeding Problems			Stroke					

Allergies

List **any allergies** you have: ☐ **NO KNOWN ALLERGIES**

_____

_____

Surgeries **If NO, Leave Blank**

TYPE	YES	Date	TYPE	YES	Date
Nephrectomy			Bladder surgeries		
Cataract Surgery			Joint Scope Surgery		
Tonsils Removed			Knee/Hip Joint Replacement		
Neck Artery Surgery			Back Disk Surgery		
Open Heart Surgery/Catheterization			Prostate Surgery		
Appendectomy			Hernia Surgery		
Gallbladder Removal			Vasectomy		
Abdominal Surgery			Hysterectomy		

Hospitalizations

Please list any recent hospitalizations including the reason, location and date:

_____

_____

Family Medical History

Check all that apply

Member	Alive or Deceased	Age	Diabetes	Kidney Disease	Cancer	Hypertension	Heart Disease	Stroke	Other
Mother									
Father									
M-Grandpa									
M-Grandma									
P-Grandpa									
P-Grandma									
Sibling(s)									
Daughter(s)									
Son(s)									

Siblings: How many brothers? _____ How many sisters? _____ Healthy ☐

Children: How many sons? _____ How many daughters? _____ Healthy ☐

Social History

Have you ever smoked? *(please check)*: ☐ Yes ☐ No

If Yes:

- For how many years? _____
- If you have stopped smoking, when did you quit? _____
- If you currently smoke, how many packs per day? _____
- Do you use smokeless tobacco? (i.e. chewing tobacco) _____

Alcohol/Drugs

- Do you drink alcohol? _____
    - If yes, how often did you have a drink containing alcohol in the past year? (Never, monthly or less, 2-4 times a month, 2-3 times a week, 4 or more times a week)
    - If yes, how many drinks did you have on a typical day when you were drinking in the past year? (1 or 2, 3 or 4, 5 or 6, 7-9, 10 or more)
    - If yes, how often did you have 6 or more drinks on one occasion in the past year? (never, less than monthly, monthly, weekly, daily, almost daily)

- Do you currently use recreational drugs? _____
    - If yes, how often and which drugs? _____
    - If no, have you used recreational drugs in the past? _____

Exercise *(please check frequency)*: ☐ Walking ☐ Rarely ☐ Occasional ☐ Never ☐ Daily ☐ Other_____

Marital Status: ☐ Single/Never married ☐ Married ☐ Divorced ☐ Widow/Widower

Living with: _____

Your Occupation: _____

Please Check All That Apply

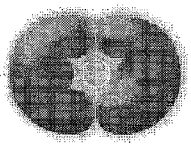
General/Constitutional	Y	N
Chills		
Fatigue		
Fever		
Night Sweats		
Unexplained Weight Loss/Gain		
Head/Eyes/Nose/Throat	**Y**	**N**
Frequent Headaches		
Severe Headaches		
Wears Glasses/Contacts		
Chronic Nasal Discharge		
Impaired Hearing		
Diabetic Eye Disease		
Endocrine	**Y**	**N**
Thyroid Problems		
Excessive Hunger		
Cold Intolerance		
Excessive Thirst		
Heat Intolerance		
Respiratory	**Y**	**N**
Asthma		
Cough		
Shortness of Breath		
Wheezing		
Cardiovascular	**Y**	**N**
Heart Trouble		
Swelling of Ankles		
Rheumatic Fever		
Chest Pain		
Irregular Heartbeat		
Palpitations		

Hematology	Y	N
Anemia		
Excessive Bleeding		
Abdominal Bleeding		
Swollen Glands/Nodes		
Women Only	**Y**	**N**
Birth Control Use		
Sexual Dysfunction		
Men Only	**Y**	**N**
Lump in Groin		
Scrotal Pain		
Sexual Dysfunction		
Genitourinary	**Y**	**N**
Blood in Urine		
Difficulty Urinating		
Frequent Urination		
Painful Urination		
Urinary Tract Infections		
Musculoskeletal	**Y**	**N**
Chronic Back Pain		
Medication for Pain		
Painful Joints		
Skin	**Y**	**N**
Oral Ulcers		
Itching		
Rash		
Skin Cancer		

Neurological	Y	N
Trouble Sleeping		
Frequest Depression		
Anxiety		
Nervousness		
Convulsions		
History of Stroke		
Numbness in Fingers/Toes		
Dizziness		
Fainting		
Memory Loss		
Seizures		
Gastrointestinal	**Y**	**N**
Hemorrhoids		
Rectal Disease		
Abdominal Pain		
Blood in Stool		
Change in Bowel Movements		
Constipation		
Decreased Appetite		
Diarrhea		

Pregnancy	
Total pregnancies?	
Total living children?	
Have you been diagnosed with preeclampsia?	
Have you been diagnosed with proteinuria?	
Total elective abortions?	
Total miscarriages?	

Reproductive Health	
Last Menstrual Cycle?	
If Applicable, what age did you go through menopause?	
Last Pap Smear?	
History of Abnormal Pap Smear? If Yes, When? What was the abnormality? What treatment did you have?	
Last Mammogram?	
History of Abnormal Mammogram? If yes, When? What was the abnormality? What treatment did you have	



THE KIDNEY & HYPERTENSION GROUP OF SOUTH FLORIDA

Patient Registration

Name: _____ **DOB:** _____ **Social Security #:** _____

Sex: ☐ Male ☐ Female **Mailing Address:** _____

Email Address: _____ **Primary Language:** _____

Would you like to join our secure portal that offers access to your medical records. Circle Yes No

How may we communicate with you regarding your health?

	Detailed Voice Messages?	Text Messages?	Automated Messages?
Home Phone: _____	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
Cell Phone: _____	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO

Primary Insurance: _____ **Secondary Insurance:** _____

PCP: _____ **Referring Provider:** _____

Local Pharmacy: _____ **Major Cross Streets:** _____

Mail Order Pharmacy: _____

Do you have an Advance Directive? (Living Will, Power of Attorney, Do Not Resuscitate) ☐ YES ☐ NO

What was the date of your last FLU vaccine? _____ Month/Year if you are unsure of the exact date

Please list all doctors you currently see (Primary Care and Specialists i.e. Cardiologist)

_____

_____

Race: ☐ **Prefer Not To Answer**

- ☐ American Indian/Eskimo
- ☐ Black/African American
- ☐ Hispanic
- ☐ Native Hawaiian/Pacific Islander
- ☐ Other Pacific Islander
- ☐ Asian
- ☐ White
- ☐ Other

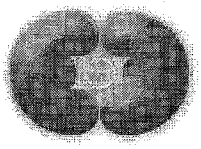
Ethnicity: ☐ **Prefer Not To Answer**

- ☐ Hispanic/Latino
- ☐ Not Hispanic/Latino

By signing below, I verify that all information is accurate and up to date,

_____ _____

Patient Signature **Date**



THE KIDNEY & HYPERTENSION GROUP OF SOUTH FLORIDA

Authorizations and Consents

***Access to Prescription History:**
I understand that prescription history from other medical providers, insurance companies, and pharmacy benefit managers may be viewable by providers and authorized staff at **the Kidney Group**. This history is viewable in our electronic medical record (EMR) system and gives our providers information they need to give you the best possible care.

I authorize the Kidney Group to view my external prescription history. ☐ **YES** ☐ **NO**

***Authorization to Share Health Information:**

Are there any family members, friends, or other person(s) involved in your care or the payment of your care that you authorize **the Kidney Group** to share your health information with? Please provide their information below.

Emergency Contact:

Name: _____ **Relation:** _____ **Phone #:** _____

Name: _____ **Relation:** _____ **Phone #:** _____

Name: _____ **Relation:** _____ **Phone #:** _____

***Insurance Authorization:**

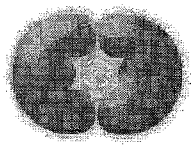
I authorize medical information released to the Social Security Administration, the Health Care Financing Administration and/or my insurance carrier as needed for this or related claims. I permit a copy of this authorization to be used in place if the original and request payment of medical insurance benefits to the Kidney Group of South Florida. Regulations pertaining to Medicare assignment of benefits apply.

_____ _____

Name of Patient (please print) **Date of Birth**

_____ _____

Patient's Signature **Date**



THE KIDNEY & HYPERTENSION GROUP OF SOUTH FLORIDA

Patient Financial Agreement

Thank you for choosing us as your Nephrology health care provider. We are committed to being a partner in providing conscientious medical care for you. Payment of the bill is considered an important part of that partnership. Thank you for reading our Financial Agreement. Please let us know if you have questions or concerns.

The following is a statement of our Financial Policy, which we require you to read and sign.

It is your responsibility:

- **To understand your benefit plan.**
- **To know if a referral is required.**
- **To know if preauthorization is required prior to a procedure, and**
- **To know what services are covered.**

Full payment for self-pay patients, co-payments and deductibles are due at the time of service. You may also be asked to pay your coinsurance at the time of service.

We accept cash, checks, Visa/MasterCard/Discover/AMEX.
Any other arrangements *must be made in advance* with our Billing Office.

Regarding Insurance:
Your insurance policy is a contract between you and your insurance company. Payment of your bill is ultimately your responsibility. **the Kidney Group** contracts with and bills most insurance carriers. If you are insured by a company with which we do not contract, we can supply you with a statement of your charges. You may submit this, along with any additional forms your insurance requires, to your insurance company.

1. **I have read and agree to this Financial Agreement.**
2. **I authorize and consent to the release of medical information necessary to bill and process insurance claims.**
3. **I authorize payment of medical benefits directly to the physician.**
4. **If we cannot successfully collect on an outstanding balance, and payment arrangements are not established within 30 days of statement, the cost of collection, including reasonable attorney fees, shall be included as part of the obligation due.**

_____ _____
Name of Patient (please print) **Date of Birth**

_____ _____
Signature of Responsible Party **Date**

The Kidney and Hypertension Group of South Florida
2001 NE 48TH CT. Suite 3-4
Fort Lauderdale, FL 33308

Voice : 954-771-3929
Fax: 954-771-2393

Authorization for Release of Medical Records

Patient Name _____ **Date of Birth** _____

Release of Medical Information **FROM**:

Practice or Doctor's Name: _____

Phone: _____ Fax Number: _____

Practice Address: _____

Release of Medical Information **TO**: Please Fax Records ☐ Please Mail Records ☐

This information may be disclosed and used by the following individual or organization:

Release To: **The Kidney and Hypertension Group of South Florida**

Address: **2001 NE 48TH CT. SUITE 3-4**
FORT LAUDERDALE, FL 33308

Phone: 954-771-3929 **Fax Number: 954-771-2393**

The Release of Medical Information is for:

☐ Change of Physician ☐ Continuation of Care ☐ Referral ☐ Other _____

☐ All information regarding assessment, diagnosis, treatment, and laboratory results for the above listed patient.

☐ All information regarding assessment, diagnosis, treatment, laboratory results for the above listed patient for the following dates: From _____ (month/year) To _____ (month/year)

☐ Other information (specify): _____

I understand that I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Practice Manager. I understand that the revocation will not apply to information that has already been released in response to this authorization. **Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____.**
If I fail to specify an expiration date, event, or condition, this authorization will expire 1 year from the date signed.

I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

I understand that authorizing the disclosure of this health information is voluntary. You may refuse to sign this authorization. Such refusal will not affect your ability to obtain treatment except to the extent that the information being requested may assist your healthcare provider in determining appropriate treatment.

I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

_____
Signature of Patient / Guardian or Authorized Representative Date

_____
Printed Name of Authorized Representative Relationship to Patient