KIDNEY CARE ASSOCIATES LLP

903-893-7170

PATIENT REGISTRATION INFORMATION

Last Name: _____ First Name: _____ M.I: _____

Social Security Number: _____ Date of Birth: _____

Address: _____ City: _____ State: ____ Zip Code: _____

Hm. Ph. _____ Cell Ph. _____

Occupation: _____ Employer: _____ Employer Ph._____

Marital Status: _____ Email: _____

Spouse's Information

Name: _____ Social Security Number: _____

DOB: _____ Occupation: _____ Employer: _____

Guarantor Information

Last Name: _____ First Name: _____ Relationship:_____

Address: _____ City: _____ State: ____ Zip Code: _____

Do you have Medicare: _____ Medicaid: _____ Medical Insurance: _____ Self Pay: _____

In Case Of Emergency

Name: _____ Phone: _____ Relationship: _____

Payment is due at the time of service, unless other arrangements have been made prior to appointment.

Please Read and Sign: I hereby consent to treatment by a Kidney Care Associates physician and understand that I am financially responsible for any and all charges whether or not paid by insurance. I hereby authorize KCA to release all information necessary to secure the payment of benefits. I further agree that a copy of this agreement shall be as valid as the original.

Signature: _____ Date: _____

Medications

Do you have any drug allergies? YES or NO List of Allergies:

_____

Please list any and all medications (including over the counter):

Medication: _____ **Dosage:** _____ **How Often:** _____

Medication: _____ **Dosage:** _____ **How Often:** _____

Medication: _____ **Dosage:** _____ **How Often:** _____

Medication: _____ **Dosage:** _____ **How Often:** _____

Medication: _____ **Dosage:** _____ **How Often:** _____

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Medication: _____ **Dosage:** _____ **How Often:** _____

Medication: _____ **Dosage:** _____ **How Often:** _____

Medication: _____ **Dosage:** _____ **How Often:** _____

Medication: _____ **Dosage:** _____ **How Often:** _____

Signature: _____ Date: _____

Physician Care Team

Referring Physician _____ **PH. ( )** _____

Primary Care Physician _____ **PH. ( )** _____

Preferred Pharmacy _____ **PH. ( )** _____

Patient's History Form

List of Problems for which you were referred:

1. _____
2. _____

Personal History

Have you or do you use tobacco? YES or NO How Much? _____

Have you or do you use Alcohol? YES or NO How Much/Often: _____

Occupation - Employed YES / NO_____ **Retired YES / NO** _____

Disabled YES / NO _____ **Homemaker YES / NO** _____

Operations

Gall Bladder: YES or NO When? _____ **Stomach: YES or NO When?** _____

Kidney: YES or NO When? _____ **Prostate: YES or NO When?** _____

Colon: YES or NO When? _____ **Thyroid: YES or NO When?** _____

Hernia: YES or NO When? _____ **Heart: YES or NO When?** _____

Any other operations: YES or NO What/When?

_____

Signature: _____ Date: _____

Family History

Kidney Failure	**YES or NO Who** _____
Dialysis	**YES or NO Who** _____
Cancer	**YES or NO Who** _____
Diabetes	**YES or NO Who** _____
Hypertension	**YES or NO Who** _____
Heart Trouble	**YES or NO Who** _____
Lung Disease	**YES or NO Who** _____

Any other serious illnesses?

System Reviews

General

Fever	**YES or NO**
Chills	**YES or NO**
Weakness	**YES or NO**
Feeling tired	**YES or NO**
Weight gain	**YES or NO**

Chest, Heart, Lungs

Shortness of breath	**YES or NO**
Cough	**YES or NO**
Sputum Production	**YES or NO**
Shortness of breath on lying down	**YES or NO**
Coughing up blood	**YES or NO**

Gastrointestinal

Poor Appetite	**YES or NO**
Difficulty swallowing	**YES or NO**
Nausea	**YES or NO**
Vomiting	**YES or NO**
Diarrhea	**YES or NO**
Black/tarry stool	**YES or NO**
Abdominal pain	**YES or NO**
Blood in stool	**YES or NO**

Signature: _____ Date: _____

Cardiovascular

Chest pain or discomfort	YES or NO
Swelling in legs/ankles	YES or NO
Palpitation	YES or NO

Genitourinary

Burning/pain with urination	YES or NO
Blood in urine	YES or NO
Frequency (>7 times a day)	YES or NO
Nocturia (>2 times a night)	YES or NO
Frothy/Foamy urine	YES or NO
Urinary incontinence	YES or NO

Musculoskeletal

Pain in several joints	YES or NO
Pain in 1-2 joints	YES or NO
Joint stiffness	YES or NO
Muscle Cramps	YES or NO
Back pain	YES or NO
Flank pain	YES or NO

Skin

Skin Lesions	YES or NO
Rashes	YES or NO
Wounds	YES or NO

Neurological

Headache	YES or NO
Dizziness	YES or NO
Passing out	YES or NO
Seizures	YES or NO
Balance problem	YES or NO
Numbness	YES or NO
Tingling	Yes or NO

Psychologic

Anxiety	YES or NO
Depression	YES or NO

Endocrine

Excessive sweating	YES or NO
Excessive thirst	YES or NO

Hematologic

Easy bleeding	YES or NO
Easy bruising	YES or NO
History of transfusions	YES or NO

Signature: _____ Date: _____