Columbus Nephrology, Inc.

PATIENT REGISTRATION FORM
PLEASE COMPLETE FRONT AND BACK

MRN (Office Use) Date:

## Patient Information

Last Name First Name Middle Initial Nickname/AKA

Mailing Address Apt# City State Zip Code

Date of Birth Social Security Number Gender ❑ Male ❑ Female ❑ Other

Preferred Phone #:_____ ❑ Cell ❑ Home ❑ Work

Alternate Phone #:_____ ❑ Cell ❑ Home ❑ Work

Email:_____

Ethnicity: ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ Declined to specify

Race: ❑ Asian ❑ American Indian/Alaska Native ❑ Black/African American ❑ Caucasian/White
❑ Native Hawaiian/Pacific Islander ❑ Other

Marital Status: ❑ Married ❑ Single ❑ Divorced ❑ Widowed

Do you have durable power of attorney? ❑ Yes ❑ No If yes, please provide a copy to the Front Desk

## Physician and Referral Information

Primary Care Physician:_____ Phone:_____

Referring Physician:_____ Phone:_____

## Emergency Contact and Confidential Communication

Emergency Contact

1 Name:_____ Phone:_____

Relationship to Patient:_____

May we speak to this person concerning your medical concerns? ❑ Yes ❑ No

2 Name:_____ Phone:_____

Relationship to Patient:_____

May we speak to this person concerning your medical concerns? ❑ Yes ❑ No

## Telecommunications

**Please leave detailed messages or contact me regarding my protected health information as follows (Check all that apply)**

**❑ Home Phone ❑ Cell Phone ❑ Work Phone ❑ Patient Portal ❑ None**

**May we leave a message to return our call on your answering machine/voice mail? ❑ Yes ❑ No**

**Preferred Method of Contact for appointment reminders:**

**❑ Home Phone ❑ Cell Phone ❑ Text**

## Insurance & Financial Information

### INSURANCE

Primary Insurance: _____

Policy Holder: _____

Relationship to Patient: _____

DOB: _____

SSN: _____

Employer: _____

Secondary Insurance: _____

Policy Holder (Secondary): _____

Relationship to Patient: _____

DOB: _____

SSN: _____

Employer: _____

### FINANCIAL POLICY

*By signing below, I indicate that I understand that all patients must complete the Columbus Nephrology, Inc. Patient Registration & Medical History forms before seeing the doctor. It is my responsibility to take an active role in my care and treatment by updating Columbus Nephrology, Inc. of any changes that have occurred since my last visit. If I have insurance, I need to bring my insurance card(s) with me to every visit and update Columbus Nephrology, Inc. if there are demographic changes. Columbus Nephrology, Inc. will send my claim to my insurance company. I authorize the release of all necessary information to file claims with my insurance company. A statement will be sent to me for any balance covered and not paid by insurance. Co-pays and deductibles are due at the time of service unless specified financial arrangements are made in advance. If I do not have insurance coverage, payment in full is expected at the time of service. Ultimately, I am responsible for payment of my bill.*

*By signing below, I am acknowledging that I have read and understand the above policy statement.*

Signed: _____ Date: _____

# PATIENT HISTORY FORM

NAME: _____ DOB ___/___/____ AGE _____ DATE _____

## MEDICAL HISTORY

DO YOU HAVE (PLEASE CIRCLE)?

KIDNEY DISEASE:

- Have you ever been told you had kidney disease or had to see a nephrologist or urologist before? No Yes
- Have you ever had a kidney biopsy? No Yes
- Have you ever been told you had blood or protein in your urine before? No Yes
- Have you ever had a kidney stone? No Yes
- Have you ever had surgery on your kidneys, urinary bladder, or prostate? No Yes

DIABETES:

- Have you been told you had diabetes? No Yes
- If so, how long ago was it diagnosed? _____
- Do you take insulin? No Yes
- Do you check your blood sugar? No Yes
- Do you have diabetic eye disease, esp. retinopathy No Yes

HIGH BLOOD PRESSURE:

- Have you ever been told you have High Blood Pressure? No Yes
- If so, how long ago? _____
- Do you take BP medicine? No Yes
- If yes, how long ago was it first prescribed? _____
- Have you ever been hospitalized or in the Emergency room due to high blood pressure? No Yes
- Do you check your BP at home? No Yes
- If so, what are your average BP readings? _____

Please describe if you have had any blood pressure medications you haven't tolerated well or reacted poorly with.

_____

_____

ILLNESSES: PLEASE PLACE A CHECK IF YOU HAVE EXPERIENCED THE FOLLOWING:

| | | | | | |
|---|---|---|---|---|---|
| Heart Attack | _____ | Congestive Heart Failure | _____ | Pacemaker/Defibrillator | _____ |
| Chest Pain | _____ | Stroke | _____ | Seizures | _____ |
| Pneumonia | _____ | Chronic Lung Disease | _____ | Asthma | _____ |
| Cancer | _____ | Liver Disease | _____ | Anemia | _____ |
| Blood Transfusion | _____ | Depression | _____ | Blood Clots/Clotting | _____ |
| Stomach/Intestinal Disorders | _____ | | | | |

**SURGICAL HISTORY:** **NAME:**_____ **DOB:** ___/___/_____

Surgery_____ Year_____ Hospital_____

Surgery_____ Year_____ Hospital_____

Surgery_____ Year_____ Hospital_____

Surgery_____ Year_____ Hospital_____

FEMALE PATIENTS:

# of pregnancies _____ # of children _____

Were you treated for high blood pressure, toxemia, or ecclampsia/preeclampsia with your pregnancies? No Yes

****Please use other side of the sheet to list additional Surgeries if needed**

**PERSONAL HISTORY:**

Single _____ Married _____ Divorced _____ Widowed _____

Live alone? No Yes Live with _____

**Employment:** Are you currently working? No Yes

If you are currently employed, what is your job? _____

**Diet:** Regular _____ Low Salt _____ Vegetarian _____

Foods told to avoid by physicians?_____

**Most Meals Are:** Cooked at home _____/per week Eaten out _____/per week (restaurants) Eaten out _____/per week (fast food)

Do you? Smoke: No Previously Currently

Usage of tobacco:_____ packs per day for _____ years

Drink Alcohol: No Previously Currently

I currently have_____ drink(s) per day/week

Drink Caffeine: No Yes _____cup(s) coffee/tea/soda per day

Exercise: No Yes _____times per week

**FAMILY HISTORY:**

Has anyone in your family (particularly your parents, brother and sisters, and your children) been told that they have kidney disease? No Yes

If yes, please explain: _____

_____

_____

**MEDICATIONS:** **NAME:** _____ **DOB:** ___/___/____

(Please note that it is very important to us to have a thorough and accurate list of your medications at each and every visit, including the names of medications that have recently changed or been stopped / started, including over-the-counter medications) **Please bring your medication in their ORIGINAL bottles.**

| Medication | Dose | Frequency |
|---|---|---|
| (example) Aspirin | 325 mg | 1 x per day |
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**ALLERGIES: Please list all medication/environmental allergies**

**I have no allergies_____**

| Allergen | Reaction |
|---|---|
| (example) Penicillin | Hives |
| | |
| | |
| | |
| | |

****Please use other side of sheet to list additional medications or allergies if needed**