Welcome to Cumberland Nephrology Associates

Patient Information:

Today's Date: _____

Last Name: _____ First Name: _____ MI:_____

Address: _____ Address 2: _____

City: _____ State: _____ Zip Code: _____

Phone #: Home _____ Work _____ Cell _____

Email Address: _____

Date of Birth: _____ Sex: Male _____ Female _____ Race: _____

SS#: _____ Marital Status: _____

Work Status: _____ Name of Employer: _____

Emergency Contact & Phone #: _____

Primary Doctor Name & Phone #: _____

Referring Doctor Name & Phone #: _____

Reason for Visit: _____

_____

Allergies:

(Please indicate any allergies to medications, dyes, foods, herbs, metals, latex or other substances.)

_____

_____

Health Maintenance:

(Please place a checkmark next to the items that you have had done in the past and the date.)

Test	Most Recent Date Done
Bone Density Scan	_____
Cholesterol	_____
Colonoscopy	_____
ECHO	_____
EKG	_____
Flu Immunization	_____
Hepatitis B Vaccine	_____
HgbA1C	_____
Mammogram	_____
Microalbumin	_____
Pneumovax Immunization	_____
PSA Test	_____
TSH	_____
Tuberculosis Test	_____
Urinalysis	_____

Patient Name: _____

Past Medical History:

(Please place a checkmark next to any condition that you have had or are currently experiencing.)

_____ AIDS
_____ Abdom. Aortic Aneurysm
_____ Alcoholism
_____ Alzheimer's Disease
_____ Anemia
_____ Anemia of Chronic Dis.
_____ Anemia, B12 Deficiency
_____ Anemia, Iron Deficiency
_____ Angina
_____ Anorexia Nervosa
_____ Anxiety
_____ Arteriosclerosis
_____ Arthritis
_____ Arthritis, Osteo
_____ Arthritis, Rheumatoid
_____ Asthma
_____ Atrial Fibrillation
_____ Atrial Flutter
_____ Ben. Prostatic Hypertrophy
_____ Bladder Infection
_____ Bleeding Disorder
_____ Bronchitis
_____ Bulimia
_____ Cancer (Indicate Location)
_____
_____
_____
_____ Cardiac Arrhythmia
_____ Carotid Artery Stenosis
_____ Cataracts
_____ Cerebrovascular Accident
_____ Chest Pain/Tightness
_____ COPD
_____ Cirrhosis
_____ Colitis
_____ Colon Disorder
_____ Colon Polyp
_____ Congestive Heart Failure
_____ Coronary Artery Disease
_____ Crohn's Disease
_____ Deep Vein Thrombosis
_____ Dementia
_____ Depression
_____ Dermatitis
_____ Diabetes, Gestational
_____ Diabetes, Insulin Dep.
_____ Diabetes, Non-Insulin Dep.
_____ Diabetes, Type 1
_____ Diabetes, Type 2
_____ Difficulty Urinating
_____ Diverticulitis
_____ Diverticulosis
_____ Drug Addiction
_____ Eczema
_____ Emphysema
_____ Enlarged Prostate
_____ Epilepsy
_____ Erectile Dysfunction
_____ Esophagitis
_____ Gallstones
_____ Gastroesophageal Reflux Disease
_____ Gout
_____ HIV Infection
_____ Headache
_____ Hearing Loss
_____ Heart Attack
_____ Heart Attack, Premature
_____ Heart Disease
_____ Heart Failure
_____ Heart Murmur
_____ Heart Valve Problem
_____ Heartburn
_____ Hepatitis A
_____ Hepatitis B
_____ Hepatitis C
_____ Hernia, Abdominal
_____ Hernia, Femoral
_____ Hernia, Hiatal
_____ Hernia, Inguinal
_____ Hernia, Umbilical
_____ Herpes Simplex
_____ High Blood Pressure
_____ High Cholesterol
_____ Hives
_____ Hodgkin's Disease
_____ Hypercholesterolemia
_____ Hypertension
_____ Hyperthyroidism
_____ Hypothyroidism
_____ Immune Function Disorder
_____ Incontinence
_____ Infectious Disease
_____ Leukemia
_____ Liver Disease
_____ Lung Disease
_____ Lupus
_____ Melanoma
_____ Mental Illness
_____ Migraine
_____ Mumps
_____ Muscle Disorder
_____ Myocardial Infarction
_____ Night Sweats
_____ Non-Hodgkin's Lymphoma
_____ Obesity
_____ Osteoporosis
_____ Palpitations
_____ Pancreatitis
_____ Parkinson's Disease
_____ Peptic Ulcer Disease
_____ Peripheral Vascular Dis.
_____ Phlebitis
_____ Pneumonia
_____ Prostate Disease
_____ Psoriasis
_____ Pulmonary Embolism
_____ Rheumatic Fever
_____ Rubella
_____ Scarlet Fever
_____ Seizure disorder
_____ Shortness of Breath
_____ Sickle Cell Anemia
_____ Sinusitis
_____ Stroke
_____ Stroke, Premature
_____ Swollen Ankles
_____ Thyroid Disease
_____ Transient Ischemic Attack
_____ Trouble Urinating
_____ Tuberculosis
_____ Tumors
_____ Ulcer, Duodenal
_____ Ulcer, Gastric
_____ Ulcer, Peptic
_____ Urethritis
_____ Venous Insufficiency
_____ Vertigo
_____ Weight Gain
_____ Weight Loss

Patient Name: _____

Smoking Hx:

_____ Never Smoker
_____ Former Smoker: Year/Age Started _____ Year/Age Stopped _____
_____ Current Smoker: Year/Age Started _____ How Much _____

Alcohol Hx:

_____ Never Used Alcohol
_____ Formerly Used Alcohol: Year/Age Started _____ Year/Age Stopped _____
_____ Currently Use Alcohol: Year/Age Started _____ Type _____ How Often _____

Family Hx: (Includes parents, grandparents, siblings, children)

Condition	Family Member	Age Diagnosed
Cancer (Type)		
High Blood Pressure		
Heart Disease (Type)		
Diabetes (Type)		
Stroke		
Mental Disease		
Kidney Disease		
Bleeding Disorders		
Drug or Alcohol Abuse		

Surgery Hx:

Date	Surgical Procedure

Hospitalizations:

Date	Reason Hospitalized

Do you have a living will? _____ No _____ Yes
Do you have a donor card? _____ No _____ Yes
Do you have any barriers that may impede the provider and or staff from providing medical care to you (language, visual and/or auditory deficits, physical or mental handicap, cultural/religious custom)? _____ No _____ Yes, please explain _____

Patient Name: _____

Insurance Information

All information must be filled out entirely in order for your visit to be billed correctly to your insurance company. Without the correct information we can't bill your insurance and you will be accountable for the bill. We need the primary insurance holder's information. (Ex: If you are the patient and you are covered under your spouse's insurance we need your spouse's information, also same with parent/child coverage.)

*Date of Birth and Social Security number are mandatory for billing purposes.

Primary Insurance:

Name of Insured: _____

Relationship to you: _____ Self: _____ No _____ Yes

Address of Insured: _____

City: _____ State: _____ Zip: _____

Phone #: _____ DOB: _____

Social Security #: _____ Employer: _____

Phone # of Employer: _____

Secondary Insurance:

Name of Insured: _____

Relationship to you: _____ Self: _____ No _____ Yes

Address of Insured: _____

City: _____ State: _____ Zip: _____

Phone #: _____ DOB: _____

Social Security #: _____ Employer: _____

Phone # of Employer: _____

Assignment of Benefits

I irrevocably assign to Cumberland Nephrology Associates all my rights and benefits under any insurance contracts for payment for services rendered to me by Cumberland Nephrology Associates. I irrevocably authorize all information regarding my benefits under any insurance policy relating to any claims by Cumberland Nephrology Associates to be released to Cumberland Nephrology Associates. I irrevocably authorize Cumberland Nephrology Associates to file insurance claims on my behalf for services rendered to me. I irrevocable direct that all such payments go directly to Cumberland Nephrology Associates. I irrevocably authorize Cumberland Nephrology Associates to act on my behalf and report any suspected violations of proper claim practices to the proper authorities. This assignment of benefits has been explained to my full satisfaction and I understand its nature and effect.

_____ _____

Signature of Patient / Responsible Party Date

Patient Name: _____

Authorization for Release of Medical Records

I hereby give my authorization to any hospital, physician or other facility that has treated or examined me to release any and all medical records to Cumberland Nephrology Associates. I also authorize Cumberland Nephrology Associates to release any and all medical records necessary for evaluation of my medical conditions to any hospital, physician, or other facility that is or will be treating me.

Signature of Patient / Responsible Party

Date

Authorization to Use and Disclose Health Information

Under the Health Insurance Portability & Accountability Act of 1996, you have certain rights to privacy regarding your protected health information. This information will be used to direct treatment among healthcare providers, obtain payment from third party payers and conduct normal healthcare operations. A more complete description of these uses is included in the **Notice of Privacy Practices.**

At Cumberland Nephrology Associates, we protect your personal, health, and financial information by complying with the national standards to protect the privacy of personal healthcare information. However, our healthcare professionals may disclose, personal, health, or financial information about patients if given permission to do so and only to those in which you identify.

Please list below those persons whom you wish to have access to your personal, health, and financial information. Again, this information will only be released to those listed below:

Name	Relationship

My signature also gives permission to leave a message on my home/work answering machine/voice mail and my cellular phone.

I acknowledge that the Cumberland Nephrology Associate's **Notice of Privacy Practices** has been made available to me and I understand that once Cumberland Nephrology Associates discloses any information to any of the above persons, that Cumberland Nephrology Associates cannot guarantee that the recipient will not re-disclose my health information to a third party. Any such third party may not be required to abide by this Authorization or applicable Federal and State Law governing the use and disclosure of my health information. I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my health information. By my signature below, I hereby, knowingly and voluntarily, authorize Cumberland Nephrology Associates to use or disclose my health information in the matter described and to those that I have designated above.

Signature of Patient / Responsible Party

Date

TERM: This authorization will remain in effect from the date of authorization until otherwise notified in writing.

Patient Name: _____