Renal Physicians of Georgia, P.C.

Date: _____

Patient Legal Name: _____ Date of Birth: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Mailing Address (if different from home): _____

Sex: (circle one) Male / Female Race: _____ Ethnicity: _____

Email: _____

Cell # _____ Home # _____

Best way to contact? (Circle one) Home Cell

SSN: _____ Marital Status: _____

Please indicate which location you would like to schedule your Renal Ultrasound at.

Circle one: Houston Healthcare Pavilion Perry Hosp. Other: _____

Emergency

Emergency Contact Name: _____ Relation: _____

Emergency contact # _____

Insurance

Primary: _____ Policy # _____

Secondary: _____ Policy # _____

Primary Care Doctor: _____

Pharmacy Name & Location: _____

I hereby state all the information I have given is true and correct to the best of my knowledge.

Patient Signature: _____ Date: _____

RELEASE OF INFORMATION AND ASSIGNMENTS OF BENEFITS DECLARATION

I hereby authorize release of any medical information necessary to process my insurance claims. Furthermore, I assign RENAL PHYSICIANS OF GEORGIA PC and/ or its doctors any and all payments from my insurance for services rendered. I understand and agree to the above conditions. A copy of this authorization shall be as valid and the original.

Patient Signature: _____ Date: _____

I understand if I email my personal health information to the office that I am sending at my own risk and the information may not be secure.

Signature: _____

Name: _____Date of Birth: _____

Medications:

Please provide an accurate medication list below:

_____ _____ _____

_____ _____ _____

_____ _____ _____

Social History:

YES/ NO Do you smoke? If yes, how many packs per day? _____ how many years? _____

YES/ NO Do you consume alcohol? If yes, how much? _____

YES/ NO Do you drink caffeine? If yes, how much per day? _____

YES/ NO Do you exercise regularly?

YES/ NO Do you use illegal drugs? If so what and how often? _____

YES/ NO Have you ever received a blood transfusion?

YES/ NO Do you have a living will?

Personal Medical History:

Please indicate if you have had any of the following problems **currently** or in the **past.**

- Anemia
- Arthritis
- Asthma
- Bladder infection
- Chronic Diarrhea
- Diverticulosis
- Diabetes, if yes, what age were you diagnosed?
- Epilepsy
- Gallstones
- Gout
- Heart disease

Name: _____ Date of Birth: _____

- ☐ High cholesterol
- ☐ High blood pressure
- ☐ Kidney disease/ kidney stones
- ☐ Liver disease/ hepatitis
- ☐ Sleep apnea
- ☐ Stroke
- ☐ Thyroid disease
- ☐ Tuberculosis
- ☐ Tumors/ cancer
- ☐ Ulcers (stomach or intestinal)

If yes to any of the above, please explain:

_____

_____

Family History:

FATHER:

- ☐ Living, Age? __
- ☐ Deceased, Age at death? ___ Cause of death? _____

MOTHER:

- ☐ Living, Age?
- ☐ Deceased, Age at death? ___ Cause of death? _____

SIBLING:

- ☐ Living, Age? ___
- ☐ Deceased, Age at death? ___ Cause of death? _____

Other illness or disease in your family:

Name: _____ Date of Birth: _____

Family member	Illness/ Disease
_____	_____
_____	_____

Allergies:

Allergy:	Reaction:
_____	_____
_____	_____
_____	_____

Hospitalization:

Please list any past hospitalizations. Include approximate date.

Date:	Hospital:	Reason:
_____	_____	_____
_____	_____	_____
_____	_____	_____

Name: _____ Date of Birth: _____

HIPPA PATIENT ACKNOWLEDGMENT

My signature indicates that I have been given the chance to review a current copy of RENAL PHYSICIANS OF GEORGIA "Notice of Privacy Practices"

Please list below who you want to have access to your health information:

NAME:	**RELATIONSHIP:**
_____	_____
_____	_____
_____	_____

Patient signature: _____ Date: _____