COMPREHENSIVE KIDNEY CARE OF SOUTH FLORIDA

Patient Information

Demographics

Last Name: _____ First Name: _____ MI: _____

Sex: ☐ Male ☐ Female DOB: ____/____/_____ SSN: _____-_____-_____

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Domestic Partner

Preferred Language: ☐ English ☐ Spanish ☐ Creole ☐ Other (please specify) _____

Home Phone: _____ Cell Phone: _____

Address: _____ City: _____ State & Zip: _____

Employer: _____ Phone: _____ ☐ Retired

Referring/Primary Doctor: _____ Phone: _____

Emergency Contacts

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

Insurance Information

Primary Insurance Name: _____ ID #: _____ Group # _____

Subscriber Name: _____ DOB: ____/____/____ SSN: _____-_____-____

Claims Address: _____ City: _____ State & Zip: _____

Secondary Insurance Name: _____ ID #: _____ Group # _____

Subscriber Name: _____ DOB: ____/____/____ SSN: _____-_____-____

Claims Address: _____ City: _____ State & Zip: _____

PATIENT FINANCIAL RESPONSIBILITY FORM

Thank you for choosing Comprehensive Kidney Care as part of your healthcare team. We are committed to providing you with the highest quality healthcare. We ask that you read and sign this form to acknowledge your understanding of our patient financial policies.

Patient Financial Responsibilities

- The patient (or patient's guardian, if a minor) is ultimately responsible for the payment for treatment and care.
- We will bill the patient's insurance; however, the patient is responsible for providing the most correct and updated information regarding insurance.
- It is the patient's (or their guardian's) responsibility to understand their insurance benefits, including whether we are a contracted provider with their insurance company, the covered benefits and any exclusions in the insurance policy, and any pre-authorization requirements of the insurance company.
- Patients are responsible for payment of co-pays, co-insurance, deductibles and all other procedures or treatments not covered by their insurance plan.
- Please understand some insurance coverages have Out-of-Network benefits that have coinsurance charges, higher co-payments and limited annual benefits. If you receive services as part of an Out-of-Network benefit, your portion of financial responsibility may be higher than the In-Network rate.
- Co-pays are due at the time of service.
- Co-insurance, deductibles and non-covered items are due 30 days from receipt of billing.
- Patients may incur, and are responsible for payment of additional charges, if applicable. These charges may include charges for returned checks.

I have read the financial policies contained above, and my signature below serves as acknowledgement of a clear understanding of my financial responsibility. I understand that if my insurance company denies coverage and/or payment for services provided to me, I assume financial responsibility and will pay all such charges in full.

Patient Name _____

Patient/Guardian Signature _____

Date _____

Medication List

Patient Name: _____

Date of Birth: _____

Preferred Pharmacy:

Pharmacy Name: _____

Address: _____

Telephone: _____

Allergies:

Are you allergic to any medications? **YES** **NO**

If yes, please list medication name and reaction: _____

_____

Medications you are currently taking (prescription and over the counter):

Medication Name	Dosage	Times per day

Preferred Laboratory: ☐ LabCorp ☐ Quest Diagnostics ☐ Other _____

Would you like to be registered for our "MyChart" online health records portal? **YES** **NO**

If yes, please provide your e-mail address: _____

Physicians

Please list current primary care physician and specialists

Primary Care Physician: _____ Phone number: _____

Specialist: _____Phone number: _____

Specialist: _____Phone number: _____

Specialist: _____Phone number: _____

Specialist: _____Phone number: _____

Specialist: _____Phone number: _____

Medical History

Please **circle** any conditions that you have ever been diagnosed with

Acute Kidney Injury

Anemia

Atrial Fibrillation (A-fib)

Cancer (Please specify) _____

Congestive Heart Failure (CHF)

Chronic Kidney Disease (Stage _____)

Clotting Disorder

COPD

Coronary Artery Disease

Diabetes Mellitus

Diabetic Nephropathy

End Stage Renal Disease (ESRD)

GERD

Gout

Hematuria (Blood in urine)

Hepatitis B

Hepatitis C

HIV/AIDS

Hyperkalemia (High potassium)

Hyperlipidemia

Hyperparathyroidism

Hypertension (High blood pressure)

Hyponatremia (Low sodium)

Hypothyroidism

Kidney Stones

Lupus

Myocardial Infarction (Heart attack)

Nephrotic Syndrome

Osteoarthritis

Osteoporosis

Polycystic Kidney Disease

Proteinuria (Protein in urine)

Pyelonephritis

Renal Cyst

Sleep Apnea

Stroke

TIA

UTI (Urinary tract infection)

Other (Please Specify):

_____

_____

_____

_____

Surgical History

Please Select and Describe Any Past Surgeries

☐ **Abdomen Surgery:** Year _____ Description_____

☐ **Bladder Surgery:** Year _____ Description_____

☐ **CABG:** Year _____ Description_____

☐ **Cardiac Stent:** Year _____ Description_____

☐ **Cystectomy:** Year _____ Description_____

☐ **Dialysis Access:** Year _____ Description_____

☐ **Gallbladder:** Year _____ Description_____

☐ **Hysterectomy:** Year _____ Description_____

☐ **Kidney Biopsy:** Year _____ Description_____

☐ **Kidney Removal**: Year _____ Description_____

☐ **Kidney Stone:** Year _____ Description_____

☐ **Kidney Transplant:** Year _____ Description_____

☐ **Lithotripsy:** Year _____ Description_____

☐ **Parathyroid Surgery:** Year _____ Description_____

☐ **Thyroid Surgery:** Year _____ Description_____

☐ **Other:** _____

Family History

Please select any condition a member of your family has been diagnosed with

□ Anemia

Mother ___ Father ___ Sister ___ Brother ___ Maternal GM ___ Maternal GF ___ Paternal GM ___ Paternal GF ___

□ Autoimmune Disease

Mother ___ Father ___ Sister ___ Brother ___ Maternal GM ___ Maternal GF ___ Paternal GM ___ Paternal GF ___

□ Cancer

Mother ___ Father ___ Sister ___ Brother ___ Maternal GM ___ Maternal GF ___ Paternal GM ___ Paternal GF ___

□ Diabetes

Mother ___ Father ___ Sister ___ Brother ___ Maternal GM ___ Maternal GF ___ Paternal GM ___ Paternal GF ___

□ Hypertension (high blood pressure)

Mother ___ Father ___ Sister ___ Brother ___ Maternal GM ___ Maternal GF ___ Paternal GM ___ Paternal GF ___

□ Kidney Disease

Mother ___ Father ___ Sister ___ Brother ___ Maternal GM ___ Maternal GF ___ Paternal GM ___ Paternal GF ___

□ Stroke

Mother ___ Father ___ Sister ___ Brother ___ Maternal GM ___ Maternal GF ___ Paternal GM ___ Paternal GF ___

□ Heart Disease

Mother ___ Father ___ Sister ___ Brother ___ Maternal GM ___ Maternal GF ___ Paternal GM ___ Paternal GF ___

□ Dementia

Mother ___ Father ___ Sister ___ Brother ___ Maternal GM ___ Maternal GF ___ Paternal GM ___ Paternal GF ___

□ Gout

Mother ___ Father ___ Sister ___ Brother ___ Maternal GM ___ Maternal GF ___ Paternal GM ___ Paternal GF ___

□ Autosomal Dominant Polycystic Kidney Disease

Mother ___ Father ___ Sister ___ Brother ___ Maternal GM ___ Maternal GF ___ Paternal GM ___ Paternal GF ___

Social History

Tobacco Use:

☐ Current User ☐ Former User ☐ Never Used

If current/former user, please select type of tobacco used: ☐ Cigarettes ☐ Pipe ☐ Cigars

Packs/day: _____ Start Date: _____ Quit Date: _____

Smokeless Tobacco Use:

☐ Current User ☐ Former User ☐ Never Used

If current/former user, please select type of smokeless tobacco used: ☐ Snuff ☐ Chew

Start Date: _____ Quit Date: _____

Alcohol Use:

☐ Current User ☐ Former User ☐ Never Used

Type of alcohol consumed: ☐ Wine ☐ Beer ☐ Liquor

Drinks/week: _____ Start Date: _____ Quit Date: _____

Substance Use:

☐ Current User ☐ Former User ☐ Never Used

If current/former user, please indicate the drug(s) used:

☐ Marijuana ☐ Amphetamines ☐ LSD ☐ Heroin ☐ Ecstasy ☐ Cocaine ☐ Other: _____

Use/week: _____ Start Date: _____ Quit Date: _____

Living Arrangement:

☐ Alone ☐ Family Member ☐ Spouse ☐Significant Other ☐ In-Home Caregiver ☐ Assisted Living

Functional/Cognitive:

☐ Memory Deficit ☐ Hearing Loss ☐ Poor Vision/Blindness ☐ Limited Mobility

☐ Transportation Challenges