FORTWORTH RENAL GROUP

DAPO AFOLABI, MD
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GEETHANJALI RAMAMURTHY

PATIENT INFORMATION:(Please use full legal name) **DATE:_____**

Last Name:_____First Name:_____MI:_____

Address:_____

City:_____State:_____ Zip Code:_____Home Phone:(____)_____

Cell Phone:( )_____ Social Security #:_____

Date of Birth:_____ Age:_____ Sex:_____ Marital Status:_____

Race:_____ Hispanic: Y or N Preferred Language: English Spanish Other:_____

Primary Care Physician Name:_____ Phone #:_____

Pharmacy Name:_____Phone #:_____

Emergency Contact Name:_____Phone #:_____

Employer Name:_____Phone #:_____

GUARANTOR INFORMATION: (If different from patient)

Last Name:_____First Name:_____MI:____

Date of Birth:_____Social Security#:_____Relationship:_____

Employer Name:_____Phone #:_____

INSURANCE INFORMATION:

Primary:_____Address:_____

Phone #:_____ID#:_____Group #:_____

Subscriber:_____Relationship:_____

Secondary:_____Address:_____

Phone #:_____ID#:_____Group #:_____

Subscriber:_____Relationship:_____

PATIENT NAME:_____DATE:_____

Past Medical History: Please circle any that apply:

High Cholesterol Gout Obesity Hypertension (high blood pressure) Dementia Coronary artery disease

Atrial fibrillation Osteoarthritis GI Bleeding Congestive heart failure COPD Stroke Seizures

Abdominal Aortic Aneurysm Kidney stones Urinary tract infections Diabetes Hepatitis HIV

Cancer Type:_____

Review of Systems: Please circle any that you are currently experiencing

General/Constitutional: Change in appetite Chills Fatigue Fever Headache Lightheadedness
Weight gain / loss

Opthalmologic: Blurred vision Eye pain

Ears/Nose/Throat: Nose/Throat problems Nosebleeds Ringing in ears

Endocrine: Cold intolerance Difficulty sleeping Dizziness Excessive sweating Excessive thirst
Frequent urination Heat intolerance Weakness

Respiratory: Breathing problems Cough Hemoptysis

Cardiovascular: Chest pain Dyspnea on exertion Fluid accumulation in the legs Orthopnea Palpitations
Shortness of breath

Gastrointestinal: Abdominal pain Blood in stool Diarrhea Nausea Vomiting

Hematology: Bleeding problems Easy brusing Prolonged bleeding

Genitourinary: Blood in urine Difficulty urinating Frequent urination

Peripheral Vascular: Cold extremities Decreased sensation in extremities Painful extremities

Podiatric: Achilles swelling Ankle swelling Foot pain

Skin: Discoloration Dry skin Itching

Neurologic: Balance difficulty Gait abnormality Loss of strength

Problems not listed above:_____

_____

Check any surgeries and list year:

_____Appendectomy _____Kidney biopsy _____Tonsillectomy _____Prostate _____Gallbladder

_____Hysterectomy _____Pacemaker _____Breast biopsy _____Mastectomy ____Coronary artery bypass

Other:_____

Family History: please list family member and disease:

Kidney disease:_____

Diabetes:_____

Hypertension:_____

Heart Disease:_____

Cancer:_____

Other:_____

Social History: please circle and list explanation:

Marital Status: Married Single Divorced Separated Partnered Spouse deceased

Employed: Full-time Part-time Retired

Current or Previous Occupation:_____

Tobacco use: Non-smoker Previous Smoker Smoker per day: 1-9 10-19 20-39 40+

Alcohol use: None Occasional Everyday:_____

Drug use: Never Previous:_____Current:_____

Caffeine consumption: Never Some Cups per day:_____

Patient Registration Form
Disclosures & Consents & Financial Responsibility Agreement

Patient Name:_____Date of Birth:_____

ASSIGNMENTS OF INSURANCE BENEFITS:

I hereby authorize direct payment of my insurance benefits to Fort Worth Renal Group or the physician individually for services rendered to my dependents or me by the physician or under his-her supervision. I understand that it is my responsibility to know my insurance benefits and whether or not the services I am to receive are covered benefit. I understand and agree that I will be responsible for any co-pay or balance due.

MEDICARE/MEDICAID/INSURANCE BENEFITS:

I certify that the information given by me in applying for payment under these programs is correct. I authorize the release of any of my dependent's records that these programs may request. I hereby direct that payment of my or my dependent's authorized benefits be made directly to the Fort Worth Renal Group or the physicians on my behalf.

AUTHORIZATION TO MAIL, CALL, OR E-MAIL:

I certify that I understand the privacy risks of the mail, phone calls, and e-mail. I hereby authorize the Fort Worth Renal Group staff or my physician to mail, call, or email me with communications regarding my healthcare, including but not limited to such things as appointment reminders, referral arrangements, and laboratory results. I understand that I have the right to rescind this authorization at any time but notifying Fort Worth Renal Group to that effect in writing.

LAB/X-RAY/DIAGNOSTIC SERVICES:

I understand that I may receive a separate bill if my medical care includes lab, x-ray, or other diagnostic services. I further understand that I am financially responsible for any co-pay or balance due for these services if they are not reimbursed by my insurance for whatever reason.

FINANCIAL RESPONSIBILITY AGREEMENT:

I understand and agree that I will be financially responsible for any and all charges not paid by my insurance for my visits. This includes medical services or visit, lab testing, and any other screening services or diagnostic ordered by the physician or staff. I understand and agree it is my responsibility and the responsibility of the physician or clinic to know if my insurance will pay for medical services or visit. I understand and agree it is my responsibility to know if my insurance has any deductible, copayment, coinsurance, usual and customary limit and I agree to make full payment. I understand and agree it is my responsibility to know if the physician or provider I am seeing is contracted in-network with my insurance plan. If the physician I am seeing is not recognized by my insurance company or plan, it may result in claims being denied or higher out of pocket expense to me and I understand this and agree to be financially responsible and make full payment.

Patient signature:_____Date:_____

Guarantor signature:_____Date:_____
(if different form patient)

Guarantor name (please print):_____

Individual Patient's Authorization

THIS FORM IS TO CONFIRM YOUR AUTHORIZATION TO USE OR DISCLOSE YOUR PROTECTED HEALTH INFORMATION FOR A SPECIAL PURPOSE.

I,_____ give my authorization to use or disclose my protected health

information to the following individual(s) or group(s).

THIS SHOULD BE NAMES OR RELATIVES OR FRIENDS WE MAY DISCUSS YOUR HEALTH ISSUES WITH. YOU SHOULD LIST AT LEAST ONE PERSON WHO HELPS YOU WHEN YOU ARE ILL.

_____ _____

_____ _____

I authorize Fort Worth Renal Group or their representative to leave messages via the following: **Please remember in order preference.** If you don't want to be contacted by one of the following, do not place a number by it.

_____ Home answering machine

_____ Work voice mail

_____ Cell Phone

_____ Text Message

_____ EMAIL:_____

I understand that I may revoke this authorization at any time, and understand this must be done in writing.

This authorization will end only upon written notice. You must make any additions or deletions from this list in writing.

Name (Print):_____

Signature:_____

Date:_____

This must be completed in order for ANY information to be disclosed to a spouse, family member, organization, or individual that assist you with your medical care, appointments, or insurance.

Allergies:_____

_____

_____

_____

_____

Medication Log

Medication Name	Dosage	Directions