FORTWORTH RENAL GROUP

PATIENT REGISTRATION

PATIENT INFORMATION: (Please use full legal name, no nickname) **DATE:** _____

Last Name: _____ First Name: _____ Middle Initial: _____

Address: _____

City: _____ State: _____ Zip code: _____ HOME Phone: _____-_____-_____

CELL Phone: _____-_____-_____ Social Security #: _____

Date of Birth: _____ Age: ____ Sex: ____ Marital Status: _____ Driver's License #: _____

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

Primary Care Physician Name: _____ PCP office telephone #: ___-___-_____

Pharmacy Name: _____ Phone: _____-_____-_____

Pharmacy Address: _____

Height: _____ Smoker: Y N Previous: Y N If current how much: _____ Pack per day

Emergency Contact Name: _____ Emergency phone #: ___-___-_____

Employer Name: _____

Employer Address: _____

Work Phone #:_____-_____-_____Occupation: _____

GUARANTOR INFORMATION: (If different from patient)

Last Name: _____ First Name: _____ Middle Initial: __

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: _____

FORTWORTH RENAL GROUP

PATIENT NAME: _____ DATE: _____

ALLERGIES: _____

_____

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:_____

Review of Systems: Please circle all that apply.

Constitutional: Fever Chills Weight loss/gain Night sweats Weakness Fatigue Loss of appetite Nausea

Eyes: Blurriness Pain Discharge Itchiness

Ears/Nose/Throat: Hearing loss Earache Nasal drainage Sore throat

Cardio/Peripheral Vascular: Chest pain Difficulty breathing Fatigue Palpitations Edema Claudication Numbness

Respiratory: Shortness of breath Cough Wheezing Asthma

Gastrointestinal: Abdominal pain Reflux Nausea Vomiting

Genitourinary: Incontinence Hematuria/blood in urine Dysuria Frequency Kidney stones

Musculoskeletal: Joint pain Back problems Arthritis Muscle weakness

Skin: Skin lesions Rash Itching Hives

Neurologic: Fainting Focal Weakness Numbness Seizures

Psychiatric: Psychiatric history anxiety depression memory loss

Endocrine: Diabetes Hot and cold intolerance Thyroid disease

Hematologic: Anemia Bleeding Blood clotting problems Swollen glands

Sleep: Snoring Excessive daytime sleepiness Witnessed apnea

 PATIENT NAME: _____ DATE: _____

Problems not mentioned in 2 sections 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: _____

Filled out by: _____ Relationship: _____

FORTWORTH RENAL GROUP

Patient Registration Form
Disclosures & Consents & Financial Responsibility Agreement

Patient Name: _____ **Date of Birth**: _____

ASSIGNMENT OF INSURANCE BENEFITS:
I hereby authorize direct payment of my insurance benefits to Ft. 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 or 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 Ft. Worth Renal Group or the physician on my behalf.

AUTHORIZATION TO RELEASE NON-PUBLIC PERSONAL INFORMATION:
I certify that I have received and read a copy of the Ft. Worth Renal Group Patient Information Privacy Policy. I hereby authorize Ft. Worth Renal Group or the physician individually to release any of my or my dependent's medical or incidental non-public personal information that may be necessary for medical evaluation, treatment, consultation, or the processing of insurance benefits.

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 Ft. Worth Renal Group staff or my physician to mail, call, or e-mail 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 by notifying Ft. 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 service or visit, lab testing, and any other screening service 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 service 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 from patient)

Guarantor name (please print): _____

FORTWORTH RENAL GROUP

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
(Patient's Name)
health information to the following individual(s) or group(s).

THIS SHOULD BE NAMES OF RELATIVE 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 Ft. Worth Renal Group or their representative to leave messages via the following: **Please number in order of 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 assists you with your medical care, appointments, or insurance.