NEPHROLOGY
OF GEORGIA

NEW PATIENT INFORMATION SHEET

Date: _____ E mail: _____

Patient's Name: _____

Last First Middle Initial

Address (Number and Street): _____

City: _____ State: _____ Zip: _____

Phone Numbers: Cell _____ Home: _____

Date of Birth: _____ Marital Status: _____

Employer: _____ SS #: _____

PHARMACY

Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Telephone: _____

EMERGENCY CONTACT PERSON

Name: _____ Relationship:_____
Phone Numbers: Home: _____ Work: _____
Cell: _____

PRIMARY INSURANCE INFORMATION

Insurance Name: _____ Plan Type: _____
Insurance ID #: _____ Patient Relationship to Insured: _____
Policy Holder Name: _____
Policy Holder DOB: _____ Policy Holder SS #: _____
Policy Holder Address: _____

SECONDARY INSURANCE INFORMATION

Insurance Name: _____ Plan Type: _____
Insurance ID #: _____ Patient Relationship to Insured: _____
Policy Holder Name: _____
Policy Holder DOB: _____ Policy Holder SS #: _____
Policy Holder Address: _____

Please Answer the Following Questions:

1. What is the reason for your visit?

_____

_____

_____

2..Are you allergic to any medication? If yes, please list:

_____

_____

_____

3. Are you currently under the care of a doctor for any reason? If yes, please explain:

_____

_____

_____

4. Have you been hospitalized in the past five years for more than two days? If yes, please explain:

_____

_____

_____

5. Please circle any of the following you have (had):

- ❑ High blood pressure
- ❑ High cholesterol
- ❑ Stroke
- ❑ Depression
- ❑ Diabetes
- ❑ Asthma
- ❑ Neuropathy
- ❑ Arthritis
- ❑ Leg swelling
- ❑ COPD
- ❑ Anemia
- ❑ Spine disease
- ❑ Kidney stones
- ❑ GERD
- ❑ Ulcers
- ❑ Osteoporosis
- ❑ Heart disease
- ❑ Sleep apnea
- ❑ GI bleeding
- ❑ Frequent UTI
- ❑ Heart failure
- ❑ Allergies
- ❑ Hepatitis
- ❑ Irregular heart
- ❑ Heart valve problem
- ❑ Gout
- ❑ Gallbladder
- ❑ Seizures
- ❑ Heart murmur
- ❑ Vascular disease
- ❑ Cancer
- ❑ Thyroid

6. Any other serious illness?

_____

_____

_____

Review of Systems (Please indicate any personal history within the last three months):

General
- ❑ Chills
- ❑ Fever
- ❑ Night sweats
- ❑ Poor appetite
- ❑ Weight loss
- ❑ Weight gain
- ❑ Loss of energy

Eyes
- ❑ Sudden vision changes
- ❑ Double vision

Ears
- ❑ Sudden loss of hearing
- ❑ Ringing in the ears
- ❑ Frequent ear infections

Nose
- ❑ Nasal congestion
- ❑ Frequent sinus infection
- ❑ Frequent nose bleeds

Mouth/Throat
- ❑ Frequent throat infections
- ❑ Change in voice

Lungs
- ❑ Chronic cough
- ❑ Coughing up blood
- ❑ Shortness of breath with activity

Heart
- ❑ Chest pain or pressure
- ❑ Heart palpitations
- ❑ Irregular heartbeat
- ❑ Waking up short of breath
- ❑ Use many pillows to sleep

Swelling
- ❑ Legs/ankles/ feet
- ❑ Calf pain when walking

Stomach/Intestine
- ❑ Difficult swallowing
- ❑ Heartburn/ indigestion
- ❑ Stomach pain/ discomfort
- ❑ Nausea or vomiting
- ❑ Vomiting blood
- ❑ Blood in stools
- ❑ Constipation
- ❑ Chronic diarrhea
- ❑ Do you use laxatives?
- ❑ Black, tarry stools
- ❑ History of jaundice

Endocrine
- ❑ Excessive thirst
- ❑ Cold/heat intolerance
- ❑ Hot flashes

Genitourinary
- ❑ Prostate problems
- ❑ Weak/slow urine stream
- ❑ Kidney stones
- ❑ Frequent urination
- ❑ Blood in urine
- ❑ Burning with urination
- ❑ Wake at night to urinate

Nervous System
- ❑ Severe headache
- ❑ Dizziness/light headedness
- ❑ Loss of balance
- ❑ Numbness or tingling

Bones/Muscles/ Joints
- ❑ Painful joints
- ❑ Swelling of joints

Skin
- ❑ Skin rash
- ❑ Easy bruising

Blood
- ❑ Anemia
- ❑ Blood loss
- ❑ Blood transfusion

Psychiatric
- ❑ Mood swings
- ❑ Depression
- ❑ Anxiety
- ❑ Sleep problems

Other issues (please list below)

Comments/Notes:

_____

_____

_____

How did you hear about us?

- ❏ My doctor referred me

  Please List: _____

- ❏ Personal recommendation

  Please List: _____

- ❏ Dr. Garcia Sanchez is my MD at another facility

  Please List: _____

- ❏ ZocDoc
- ❏ Online search for Internist
- ❏ Online search for Nephrologist
- ❏ Other

  Please List: _____

Patient Signature (or Representative): _____

Representative Name (Print): _____

Relationship to Patient: _____

Date: _____

MEDICATIONS LIST

Please list below all medications currently being taken. Please include all prescription and over-the-counter medications as well as any vitamins and/or herbals.

PATIENT DOB: _____ NAME: _____

MEDICATION NAME	**DOSE** (20 mg,mcg,ml,etc.)	**FREQUENCY** (daily,twice daily, etc.)

ALLERGIES: Please list below all medication allergies

_____

_____

_____

Healow Patient Portal

Heslow is an application that allows for transparency with all your medical records. It is the easiest way to manage your healthcare.

With the Healow app you can:

- View results
- Check medications
- Review your health information
- See future appointments
- Send secure messages to your doctor's office

If you would like to receive an email to sign up for Healow please fill out the information below.

Email: _____

Patient Name: _____

Patient Signature: _____

AUTHORIZATION/CONSENT & HIPAA

Patient Name: _____ DOB: _____

Patient Phone #:_____

Person(s) authorized to speak on my behalf: _____

Phone Number: _____

PLEASE READ AND SIGN BELOW

_____ I authorize representatives from NEPHROLOGY OF GEORGIA to disclose and/or request protected health information to/from any medical facility and/or provider if it is medically necessary.

_____ I understand it is my responsibility to schedule appointments with specialists and/or any radiology department if I am referred to.

_____ I understand I have to contact my referring office (NEPHROLOGY OF GEORGIA) to notify once an appointment is complete and where it has been completed via these methods: patient portal, phone call, or email address.

Right and Responsibilities:

1. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization it must be done in writing and presented to Nephrology Of Georgia LLC. I understand that the revocation will not apply to any health information that has already been released.

2. I understand that if my health information is disclosed to a party other than a health care provider, health plan or health care clearinghouse subject to the federal privacy regulations, my health information disclosed pursuant to this authorization may no longer be protected by the federal privacy regulations.

3. I understand that the health information disclosed may include psychological information, chemical dependence, alcohol abuse, HIV status, and/or Hepatitis.

4. I understand that I am waiving any privilege concerning such information for the purpose of releasing it to the party authorized above. I release Nephrology Of Georgia LLC and its employees from any and all liabilities, damages and claims, which might arise from the release of the health information authorized by me.

Patient Signature (or Representative): _____

Representative Name (Print): _____

Relationship to Patient: _____

Date: _____

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. **You may request a copy to read at your convenience**

WAYS WE MAY USE AND DISCLOSE YOUR MEDICAL INFORMATION

The following sections describe different ways that we may use and disclose your medical information. Not every use or disclosure will be listed. All of the ways we are permitted to use and disclose information, however, will fall within one of the following categories.

Some information such as certain drug and alcohol information, HIV information and mental health information is entitled to special restrictions related to its use and disclosure. Our office shall abide by all applicable state and federal laws related to the protection of this information.

1. **Treatment**. We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, or other personnel who are involved in your care. For example, a doctor treating you may need to know if you have diabetes because diabetes may slow the healing process. We may also share medical information about you with our office personnel or other providers, agencies or facilities in order to provide or coordinate such things as prescriptions, lab work and x-rays. We also may disclose medical information about you to people outside our office who may be involved in your continuing medical care after you leave our office such as other health care providers, transport companies, community agencies and family members.

2. **Payment**. We may use and disclose medical information about the treatment and services you receive at our office so that payment may be collected from you, an insurance company or a third party. For example, we may need to give information to your health plan about treatment you received at our office so your health plan will pay us or reimburse you. We may also tell your health plan about a proposed treatment in order to obtain prior approval or to determine whether your plan will cover the treatment.

3. **Health Care Operations**. We may use and disclose medical information about you to support our office operations. These uses and disclosures are made to improve our quality of care. Your medical information may also be used or disclosed to comply with laws and regulations, for contractual obligations, patients. claims, grievances or lawsuits, health care contracting, legal services, business planning and development, business management and administration, the sale of all or part of our office to another entity, underwriting and other insurance activities. For example, we may review medical information to find ways to improve treatment and services to our patients. We may also disclose information to doctors, nurses, technicians, and other personnel for performance improvement and educational purposes.

4. **Appointment Reminders**. We may contact you to remind you that you have an appointment at our office.

5. **Treatment Alternatives**. We may tell you about or recommend possible treatment options or alternatives that may be of interest to you.

6. **Health-Related Benefits and Services**. We may contact you to tell you about benefits or services that we provide.

7. **Others Involved in Your Care.** We may release medical information to anyone involved in your medical care, For example, a friend, family member, personal representative, or an individual you identify. We may give information to someone who helps pay for your care or we may tell your family or friends about your general condition.

8. **Research**. Your medical information may be important to further research efforts. We may use and disclose your medical information for research purposes, subject to the confidentiality provisions of state and federal law.

9. **As Required By Law**. We will disclose medical information about you when required to do so by federal or state law; If asked to do so by law enforcement in response to a court or administrative order, subpoena, discovery request, warrant, summons or other lawful process; or for intelligence, counterintelligence, and other national security activities authorized or required by law.

10. **To Avert a Serious Threat to Health or Safety**. We may use and disclose medical information about you for public health purposes or when necessary to prevent or lessen a serious and imminent threat to your health and safety or the health and safety of the public or another person. Any disclosure would be to someone able to help stop or reduce the threat

11. **Workers' Compensation**. We may use or disclose medical information about you for Workers' Compensation or similar programs as authorized or required by law. These programs provide benefits for work-related injuries or illness.

12. **Inmates**.If you are an inmate of a correctional institution or under the custody of law enforcement officials, we may release medical information about you to the correctional institution as authorized or required by law.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU

Although the medical information we obtain about you is the property of our office, you do have the following rights:

I. **Inspect and Copy**.

II. **Request an Amendment or Addendum**.

III. **Accounting of Disclosures**.

IV. **Right to Request Restrictions**.

V. **Right to Request Confidential Communications**.

VI. **Right to a Paper Copy of This Notice**.

CHANGES TO OUR PRIVACY PRACTICES AND THIS NOTICE

We reserve the right to change our office's privacy practices and this Notice. We reserve the right to make the revised or changed Notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current Notice at our office. The Notice will contain the effective date on the first page in the top right-hand corner. In addition, at any time you may request a copy of the current Notice in effect.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with our our Privacy Office or with the Secretary of the Department of Health and Human Services. To file a complaint please contact our Privacy Officer by mail at Office for Civil Rights Department of Health & Human Services 61 Forsyth Street, SW. - Suite 3B70 Atlanta, GA 30323 (404) 562-7886; (404) 331-2867 (TDD) (404) 562-7881 FAX. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

OTHER USES OF MEDICAL INFORMATION

Other uses and disclosures of medical information not covered by this Notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we will retain our records of the care provided to you as required by law.

Patient Signature (or Representative): _____

Representative Name (Print): _____

Relationship to Patient: _____

Date: _____