Western Nephrology
Caring for People with Kidney Disorders

Please come prepared to give a urine sample and complete the attached forms and bring them with you to your appointment.

We look forward to seeing you at the above date and time. In order to make this appointment with the consulting doctor more efficient and beneficial, we ask that you do the following:

If you have insurance that requires a referral, you must check with your referring physician before your appointment to make sure that they have sent us a copy. If we do not have written verification, your appointment may have to be rescheduled or payment of the visit may become your responsibility.
Please arrive at your appointment approximately 30 minutes before the appointed time to complete your registration.

- Please bring all of your pill bottles, including any vitamins and herbal supplements.
- Please provide the most up to date and accurate information regarding your current concerns and past medical history.
- Please call no less than 48 hours in advance if you need to cancel or reschedule your appointment.

By providing the above information your appointment will run smoothly and your Kidney Care Team will be able to provide you with the best care possible.

Sincerely,

Western Nephrology Staff

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Caring for People with Kidney Disorders

Patient Registration

Name: _____ **DOB:** _____ **Social Security #:** _____

Sex: ☐ Male ☐ Female **Mailing Address:** _____

Email Address: _____ **Primary Language:** _____

How may we communicate with you regarding your health?

	Detailed Voice Messages?	Text Messages?	Automated Messages?
Home Phone:_____	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
Cell Phone: _____	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO

Primary Insurance: _____ **Secondary Insurance**: _____

PCP: _____ **Referring Provider:** _____

Local Pharmacy: _____ **Major Cross Streets:** _____

Mail Order Pharmacy: _____

Do you have an Advance Directive? (Living Will, Power of Attorney, Do Not Resuscitate) ☐ YES ☐ NO

What was the date of your last FLU vaccine? _____Month/Year if you are unsure of the exact date

Please list all doctors you currently see (Primary Care and Specialists i.e. Cardiologist)

_____

_____

Race: ☐ **Prefer Not To Answer**

☐ American Indian/Eskimo
☐ Black/African American
☐ Hispanic
☐ Native Hawaiian/Pacific Islander
☐ Other Pacific Islander
☐ Asian
☐ White
☐ Other

Ethnicity: ☐ **Prefer Not To Answer**

☐ Hispanic/Latino
☐ Not Hispanic/Latino

By signing below, I verify that all information is accurate and up to date,

_____ _____
Patient Signature **Date**

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Authorizations and Consents

***Access to Prescription History:**
I understand that prescription history from other medical providers, insurance companies, and pharmacy benefit managers may be viewable by providers and authorized staff at Western Nephrology. This history is viewable in our electronic medical record (EMR) system and gives our providers information they need to give you the best possible care.

I authorize Western Nephrology to view my external prescription history. ☐ **YES** ☐ **NO**

***Authorization to Share Health Information:**

Are there any family members, friends, or other person(s) involved in your care or the payment of your care that you authorize Western Nephrology to share your health information with? Please provide their information below.

Emergency Contact:

Name: _____ **Relation:** _____ **Phone #:** _____

Name: _____ **Relation:** _____ **Phone #:** _____

Name: _____ **Relation:** _____ **Phone #:** _____

***Controlled Substance Notification:**

If we prescribe you a "controlled" medication, your prescription information will be entered into Colorado's Prescription Drug Monitoring Program (PDMP) Database. The database is protected and your health record can only be accessed by caregivers or law enforcement officers in the case of an authorized investigation. You have the right to access your information in the PDMP through the Colorado Board of Pharmacy. You may also seek corrections to information in the database.
For more information go to: http://hidinc.com/copdmp

_____ _____
Name of Patient (please print) **Date of Birth**

_____ _____
Patient's Signature **Date**

Western Nephrology
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Patient Financial Agreement

Thank you for choosing us as your Nephrology health care provider. We are committed to being a partner in providing conscientious medical care for you. Payment of the bill is considered an important part of that partnership. Thank you for reading our Financial Agreement. Please let us know if you have questions or concerns.

The following is a statement of our Financial Policy, which we require you to read and sign.

It is your responsibility:

- **To understand your benefit plan.**
- **To know if a referral is required.**
- **To know if preauthorization is required prior to a procedure, and**
- **To know what services are covered.**

Full payment for self-pay patients, co-payments and deductibles are due at the time of service. You may also be asked to pay your coinsurance at the time of service.
In the event that you are unable to pay the full amount of your deductible or coinsurance at the time of service, you will be asked to pay at least a $50 deposit towards the total amount due.

We accept cash, checks, Visa/MasterCard/Discover/AMEX.
Any other arrangements *must be made in advance* with our Billing Office.

Regarding Insurance:
Your insurance policy is a contract between you and your insurance company. Payment of your bill is ultimately your responsibility. Western Nephrology contracts with and bills most insurance carriers. We also participate with both Medicare and Medicaid of Colorado. If you are insured by a company with which we do not contract, we can supply you with a statement of your charges. You may submit this, along with any additional forms your insurance requires, to your insurance company.

1. **I have read and agree to this Financial Agreement.**
2. **I authorize and consent to the release of medical information necessary to bill and process insurance claims.**
3. **I authorize payment of medical benefits directly to the physician.**
4. **If we cannot successfully collect on an outstanding balance, and payment arrangements are not established within 30 days of statement, the cost of collection, including reasonable attorney fees, shall be included as part of the obligation due.**

_____ _____
Name of Patient (please print) **Date of Birth**

_____ _____
Signature of Responsible Party **Date**

Name: «FirstName» «LastName»
DOB: _____
Date of Appointment: «NextAppt»

What was the date of your last FLU Vaccine? _____ Month/Year if you don't know the exact date

Medications

Please list any medications you currently taking along with **dosage and directions** (including birth control, vitamins and OTC medications):

☐ **I brought all my bottles with me** ☐ **See attached/below medication list**

_____

_____

_____

_____

Medical History – Health Conditions

CONDITION	Y	N	CONDITION	Y	N	CONDITION	Y	N
Kidney Disease			Kidney Stones			Epilepsy/Seizures		
Irregular Heart Beat			Tuberculosis			Thyroid Problems		
High Blood Pressure			Gallstones			Anemia		
Heart Attack			Liver Disease			Asthma		
Heart Murmur			Ulcers in Stomach/Bowels			Blood Transfusion		
Rheumatic Fever			Bleeding from Bowels			Depression		
High Cholesterol			Arthritis			Anxiety		
Congestive Heart Failure			Prostate Problems			Cancer		
Emphysema/Chronic Bronchitis			Gout			Details:		
Blood Clot in Lung			Skin Disease					
Blood Clot in Leg			Diabetes/High Blood Sugar			Other:		
Bleeding Problems			Stroke					

Allergies

List **any allergies** you have: ☐ **NO KNOWN ALLERGIES**

_____

_____

Surgeries **If NO, Leave Blank**

TYPE	YES	Date	TYPE	YES	Date
Nephrectomy			Bladder surgeries		
Cataract Surgery			Joint Scope Surgery		
Tonsils Removed			Knee/Hip Joint Replacement		
Neck Artery Surgery			Back Disk Surgery		
Open Heart Surgery/Catheterization			Prostate Surgery		
Appendectomy			Hernia Surgery		
Gallbladder Removal			Vasectomy		
Abdominal Surgery			Hysterectomy		

Hospitalizations

Please list any recent hospitalizations including the reason, location and date:

_____

_____

Family Medical History

Check all that apply

Member	Alive or Deceased	Age	Diabetes	Kidney Disease	Cancer	Hypertension	Heart Disease	Stroke	Other
Mother									
Father									
M-Grandpa									
M-Grandma									
P-Grandpa									
P-Grandma									
Sibling(s)									
Daughter(s)									
Son(s)									

Siblings: How many brothers? _____ How many sisters? _____ Healthy ☐

Children: How many sons? _____ How many daughters? _____ Healthy ☐

Social History

Have you ever smoked? *(please check)*: ☐ Yes ☐ No

If Yes:

- For how many years? _____
- If you have stopped smoking, when did you quit? _____
- If you currently smoke, how many packs per day? _____
- Do you use smokeless tobacco? (i.e. chewing tobacco) _____

Alcohol/Drugs

- Do you drink alcohol? _____
    - If yes, how often did you have a drink containing alcohol in the past year? (Never, monthly or less, 2-4 times a month, 2-3 times a week, 4 or more times a week)
    - If yes, how many drinks did you have on a typical day when you were drinking in the past year? (1 or 2, 3 or 4, 5 or 6, 7-9, 10 or more)
    - If yes, how often did you have 6 or more drinks on one occasion in the past year? (never, less than monthly, monthly, weekly, daily, almost daily)

- Do you currently use recreational drugs? _____
    - If yes, how often and which drugs? _____
    - If no, have you used recreational drugs in the past? _____

Exercise *(please check frequency)*: ☐ Walking ☐ Rarely ☐ Occasional ☐ Never ☐ Daily ☐ Other_____

Marital Status: ☐ Single/Never married ☐ Married ☐ Divorced ☐ Widow/Widower

Living with: _____

Your Occupation: _____

Please Check All That Apply

General/Constitutional	Y	N
Chills		
Fatigue		
Fever		
Night Sweats		
Unexplained Weight Loss/Gain		
Head/Eyes/Nose/Throat	**Y**	**N**
Frequent Headaches		
Severe Headaches		
Wears Glasses/Contacts		
Chronic Nasal Discharge		
Impaired Hearing		
Diabetic Eye Disease		
Endocrine	**Y**	**N**
Thyroid Problems		
Excessive Hunger		
Cold Intolerance		
Excessive Thirst		
Heat Intolerance		
Respiratory	**Y**	**N**
Asthma		
Cough		
Shortness of Breath		
Wheezing		
Cardiovascular	**Y**	**N**
Heart Trouble		
Swelling of Ankles		
Rheumatic Fever		
Chest Pain		
Irregular Heartbeat		
Palpitations		

Hematology	Y	N
Anemia		
Excessive Bleeding		
Abdominal Bleeding		
Swollen Glands/Nodes		
Women Only	**Y**	**N**
Birth Control Use		
Sexual Dysfunction		
Men Only	**Y**	**N**
Lump in Groin		
Scrotal Pain		
Sexual Dysfunction		
Genitourinary	**Y**	**N**
Blood in Urine		
Difficulty Urinating		
Frequent Urination		
Painful Urination		
Urinary Tract Infections		
Musculoskeletal	**Y**	**N**
Chronic Back Pain		
Medication for Pain		
Painful Joints		
Skin	**Y**	**N**
Oral Ulcers		
Itching		
Rash		
Skin Cancer		

Neurological	Y	N
Trouble Sleeping		
Frequest Depression		
Anxiety		
Nervousness		
Convulsions		
History of Stroke		
Numbness in Fingers/Toes		
Dizziness		
Fainting		
Memory Loss		
Seizures		
Gastrointestinal	**Y**	**N**
Hemorrhoids		
Rectal Disease		
Abdominal Pain		
Blood in Stool		
Change in Bowel Movements		
Constipation		
Decreased Appetite		
Diarrhea		

Pregnancy	
Total pregnancies?	
Total living children?	
Have you been diagnosed with preeclampsia?	
Have you been diagnosed with proteinuria?	
Total elective abortions?	
Total miscarriages?	

Reproductive Health	
Last Menstrual Cycle?	
If Applicable, what age did you go through menopause?	
Last Pap Smear?	
History of Abnormal Pap Smear? If Yes, When? What was the abnormality? What treatment did you have?	
Last Mammogram?	
History of Abnormal Mammogram? If yes, When? What was the abnormality? What treatment did you have	