PATIENT INFORMATION

Patient Name: ____ Birthdate: __________

Age: _______ Gender: _____________________ Marital Status: ________________________

Address: ____

City: ________________________________ State: _______________ Zip Code:____________

Phone (home): ____________________ Phone (cell): _____________________ Ok to text Y / N

Email Address : ____

Social Security #: ________________________ Preferred Language: _____________________

Ethnicity: ______________________________ Race:___________________________________

Emergency Contact: __________________Relationship: ______________Phone: __________

Primary Physician: ___________________ Referred by: _______________________________

Preferred Pharmacy: _____________________ Cross Streets: __________________________

Pharmacy Phone # ______________________

Employer: ___________________________ Employer Phone: ____________________________

Financially Responsible Party: ____

Address (if different than above): ____

Name of Insurance Company: ____

Policy Number: ____________________________________ Group #____________________

I request that payment of authorized insurance benefits be made on my behalf to Albuquerque Nephrology Associates for any services furnished to me by my physician or nurse practitioner. I authorize any holder of medical information about me to release it to the Health Care Financing Administration and/or insurance companies as needed to determine these benefits or benefits payable for related services.

I authorized Albuquerque Nephrology Associates to use the phone number and/or emergency contact number to relay any laboratory or medical results or appointment information, or to leave such information on an answering machine or via text message.

Signature: ______________________________________ Date: _________________________

Height ______________________________ Weight ______________________________________

Patient History:

Please List all medical conditions for which you have been diagnosed or treated:

Please List all surgeries you have undergone, including biopsies, prostheses, and devices.

Family Medical History:

Relation	Medical condition (High Blood pressure/Heart Disease/ Kidney Disease/Cancer/Diabetes
Father	
Mother	
Siblings(specify)	
Children (specify)	
Paternal Grandfather	
Paternal Grandmother	
Maternal Grandfather	
Maternal Grandmother	

Allergies:

Allergies to Medications	Reaction

PATIENT MEDICATIONS:

Medications: (including over the counter, herbals and supplements)

Medication Name	Dose	Frequency

Social history:

Alcohol Use: Yes No If yes, how much? _______________ (Per day/week/month)

Tobacco Use: Yes No If yes, how much? ____________ / and for how many years? ___________

Former Smoker: For how many years? __________ when did you stop smoking? _______________

Do you follow a diet? Yes No If yes, what kind? ____

Do you exercise? Yes No If yes, how often: __________ What kind of exercise: ____________

KNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES. (§164.520(a))

I,________________________________, (patient's name) understand that as part of my healthcare, this facility originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I acknowledge that I have been provided with and understand that this facility's Notice of Privacy Practices provides a complete description of the uses and disclosures of my health information. I understand that:

- I have the right to review this facility 's Notice of Privacy Practices prior to signing this acknowledgement.
- This facility reserves the right to change their Notice of Privacy Practices and prior to implementation of this will mail a copy of any revised notice to the address I've provided if requested.

Signature of patient or Legal Representative ____________________________________

Print patient name or Legal Representative _______________________________________

Date: ________________

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but it could not be obtained because:

O Individual refused to sign

O Communication Barrier prohibited obtaining the acknowledgement

O An emergency situation prevented us from obtaining acknowledgement

O Other (please specify) ____

____

Staff signature ____ Date _____________________________

Authorization to Disclose Health Information

I authorize Albuquerque Nephrology Associates to release my patient information: laboratory results, diagnoses and appointment information to:

_______ Spouse (print name): ____

_______ Mother (print name): ____

_______ Father (print name): ____

_______ Children (print name or names):____

____

_______ Other Family Members or Caregivers (print names): ______________________________