Greater Houston Kidney Clinic

Questionnaire

Patient Name _____ Date of Birth _____/_____/_____ M F

Address _____ City _____ Zip _____

SS# _____- _____- _____ Email Address _____

Primary Telephone # (_____) _____-_____ Secondary Telephone # (_____) _____-_____

Emergency Contact Name _____ Phone # (_____) _____-_____

Marital Status Single Married Divorced Widowed

Name of Primary Care Doctor _____ Phone # (_____) _____-_____

Name of Pharmacy _____ Phone # (_____) _____-_____

Please provide insurance card (s) and photo identification upon check-in

Primary Insurance _____ Policy Holder/Relation _____

Member ID # _____ Group # _____

Secondary Insurance _____ Policy Holder/Relation _____

Member ID # _____ Group # _____

Why are you here to see a Nephrologist (Kidney) doctor? (reason for today's visit)

_____

_____

Name of referring physician/person _____

Have you ever been diagnosed with a kidney problem Yes No?

If Yes, please explain

_____

_____

Assignment and release

I, undersigned certify that (or my dependent) have insurance coverage as indicated above directly to Greater Houston Kidney Clinic all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether paid by my insurance. I hereby authorize the use of this signature of all insurance submissions. I have received, read and understand all documents given to me in regards to HIPPA rights as a patient, If the patient is a minor, I content to evaluation and treatment.

Signature _____ Date _____/____/_____

Patient Record of Disclosures

The HIPPA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI is made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

Home phone # (_____) _____-_____

_____ Leave message with detailed information

_____ Leave message with call back number only

Cell phone # (_____) _____-_____

_____ Leave message with detailed information

_____ Leave message with call back number only

Work phone # (_____) _____-_____

_____ Leave message with detailed information

_____ Leave message with call back number only

Written Communication

_____ Okay to mail to my home address

_____ Okay to mail to my work/office address

_____ Okay to fax to the following number (_____) _____-_____

Please list names of any individuals you would like you PHI to be disclosed to

Name	Relationship
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Signature _____ Date _____/_____/_____

Patient Name _____ Date _____/_____/_____

Are you currently or have you ever taken the following medications? If yes, how many tablets per day or week (on average) and for how long? Day _____ week _____ how long _____.

Motrin, Ibuprofen, Advil, Aleve (Nephrosyn, Naproxen), Mobic, Goody's Powders, BC Tablets/Powder, Celebrex, Vioxx, Bextra, Diclofenac, Voltaren.

Medication Allergies	Reaction
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

_____ No Known Drug Allergies

* If you have a detailed mediation list with you, please turn in with paperwork and skip this section.

Medication list

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Social History

_____ Never Smoker

_____ Former Smoker

_____ Quit Smoking When? _____ Average pack _____ Day _____ Years Smoked _____

_____ Currently Smoking Average Packs _____ Day _____ Years Smoked _____

Do you drink Alcohol? Yes No how often? _____

Patient Name _____ Date _____/_____/_____

Medical History

_____ Hypertension (High Blood Pressure)
_____ Hypercholesterolemia (High Cholesterol)
_____ Neuropathy from Diabetes
_____ Stents in Heart
_____ Congestive Heart Failure (CHF)
_____ Emphysema or Bronchitis
_____ Bleeding form Digestive tract
_____ Hepatitis B Or C
_____ Arthritis
_____ Thyroid Disease
_____ Migraine Headaches
_____ Kidney stones
_____ Blood Clots
_____ Diabetes Mellitus
_____ Eye problems from Diabetes Mellitus
_____ Heart Attack
_____ Pacemaker or Irregular Heart Rhythm
_____ Stroke (CVA)
_____ Heart Burn (Acid Reflux)
_____ Liver Disease
_____ Enlarge Prostate
_____ Cancer (List type) _____
_____ Gout
_____ Seizures
_____ Anemia
_____ Kidney Disease

List any other medical conditions that you have had in the past _____

_____

_____

Hospitalization

Hospital Name	Reason	Approximate Date

Surgical Procedures

Procedure	Approximate Date

Family History

Relationship	Conditions or Diseases	Age	Deceased
Mother			Y N
Father			Y N
Sister			Y N
Brother			Y N
Son			Y N
Daughter			Y N

Review of Systems

Please check all that apply.

General

_____ Fever
_____ Sweats
_____ Tired or Weak
_____ Weight loss or weight gain
_____ Loss of appetite
_____ Feeling cold
_____ Napping during the day

Urinary

_____ Feeling of not emptying bladder completely
_____ Pain with urination
_____ Blood in urine
_____ Foamy urine
_____ Smelly urine
_____ Stones or tissue in urine

Head and Neck

_____ Sinus problems
_____ Bloody nose
_____ Vision problems besides glasses
_____ Lumps or bumps in neck

Blood

_____ Excessive bruising
_____ Excessive bleeding
_____ Lumps or bumps anywhere

Heart/Circulation

_____ Chest pain or pressure lying down
_____ Skipping heart beats
_____ Shortness of breath when lying down
_____ Leg or finger swelling
_____ Swelling around the eyes
_____ Pain in the legs when walking

Neurologic

_____ Lightheadedness or dizziness
_____ Numbness or tingling in feet
_____ Numbness or tingling in hands
_____ Numbness around mouth
_____Muscle twitching
_____ Muscle cramps
_____ Falls or near falls

Abdomen

_____ Nausea
_____ Vomiting
_____ Trouble with swallowing
_____ Heartburn or indigestion
_____ abdominal pain
_____ Diarrhea
_____ Severe constipation
_____ Bloody or black stool

Mental Health

_____ Depression, feeling down
_____ Anxiety
_____ Stress

Skin

_____ Rash
_____ Purple spots or lines
_____ Skin sores

Lungs

_____ Cough
_____ Sputum production
_____ Snoring
_____ Shortness of breath at rest

Bones and Joints

_____ New or unexplained bone pain
_____ Hot, red, or swollen joints
_____ Change in arthritis pain

HIPPA Notice of Privacy Practices
Greater Houston Kidney Clinic
24044 Highway 59 North
Kingwood, TX. 77339

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.

This notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purpose that are permitted or required by law. It also describes your right to access and control you PHI. "Protected Health Information" is information about you, including demographic information that may identify you that relates to your past, present or future physical or mental health condition and related to your past, present or future physical or mental health condition and related health care services.

Uses and Disclosure of Protected Health Information: Your PHI may be used and disclosed by your physician, our office staff and other outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your PHI to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your PHI, as necessary, to a home health agency that provides care to you. For example, your PHI may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or threat you.

Payment: Your PHI will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant PHI to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your PHI in order to support the business activities of your physicians practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your PHI to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your PHI, as necessary, to contact you're to remind you of your appointment.

We may use or disclose your PHI in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, Health oversight, Abuse or neglect, Food and Drug Administration requirements, Legal Proceedings, Law Enforcement, Coroners, Funeral Directors and Organ Donation, Research, Criminal Activity, Military Activity, and National Security, Workers Compensation, Inmates, Required uses and disclosure. Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requiems of section 164.500.

Other Permitted and Required Uses and Disclosures will be made only will your consent, authorization or opportunity to object unless by law.

You may revoke this authorization at any time, in writing, except to the extent that your physician or the physicians practice has taken action in reliance on the disclosure indicated in the authorization.

Your Rights: Following is a statement of your rights with respect to your PHI. You have the right to inspect and copy your PHI. Under federal law, however you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable of, or use in a civil, criminal, or administrative action or proceeding, and PHI that is subject to law that prohibits access to PHI.

You have the right to request a restriction of you PHI. This means you may us not to use or disclose any part of your PHI for the purpose of treatments, payment or healthcare operations. You may also request that any part of your PHI not be disclosed to family member or friends who may be involved in your care of the notification purpose as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply .

Your physician is not required to agree to a restriction that may request. If physician believes it is in your best interest to permit use and disclosure of you PHI, your PHI will not be restricted. You then have the right to use another healthcare professional.

You have the right to request to receive confidential communications from us be alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your PHI. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your PHI.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdrew as provided in this notice.

Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

This notice was published and becomes effective on or before June 5, 2015.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected healthcare information. If you have any objections to this form, please ask to speak with our HIPPA Compliance Officer in person or by phone at our main phone number.

Signature below is only acknowledgement that you received this notice of our Privacy Practices:

Print Name _____ Signature _____ Date _____