Kidney Specialists, PC
1230 South Cedar Crest Blvd., Suite 301 • Allentown, PA 18103

PATIENT DEMOGRAPHIC SHEET

Referring Doctor: ______________________ Phone: ______________________

Family Doctor: ______________________ Phone: ______________________

Last Name: ______________________ First Name: ______________________

Address: ____

City: ______________________ State: __________ Zip Code: ______________

Home Phone #: ______________________ Cell Phone #: ______________________

Work Phone #: ______________________ Emergency Phone #: ______________________

Date of Birth: ______________________ Social Security #: ______________________

Sex: M - F Marital Status: S - M - D - W Spouse's Name: ______________________

Emergency Contact

Name: ______________________ Phone: ______________________

Primary Insurance

Company Name: ______________________

ID Number: ______________________

Group Number: ______________________

Subscriber's Name: ______________________

Subscriber's DOB: ______________________

Secondary Insurance

Company Name: ______________________

ID Number: ______________________

Group Number: ______________________

Subscriber's Name: ______________________

Subscriber's DOB: ______________________

MEDICARE AND MEDICAID AUTHORIZATION AND ASSIGNMENT

I request payment of authorized Medicare/insurance benefits be made on my behalf to Valley Kidney Specialists, PC for any medical services furnished to me. I authorize Valley Kidney Specialists, PC to release my medical information necessary to determine benefit coverage to the Centers for Medicare and Medicaid Services and/or its agents.

Signature: ____________________________________ Date: ______________

ALL PATIENTS TREATMENT AUTHORIZATION AND ASSIGNMENT

My signature authorizes the physicians of Valley Kidney Specialists, PC to provide medical treatment to me and submit claims to my insurance for treatment on my behalf. I understand that I am financially responsible for the medical care provided to me, and any balances not covered by insurance are due in full to Valley Kidney Specialists, PC.

Signature: ____________________________________ Date: ______________

COMPLETE BOTH SIDES

Continued

I ____ authorize Valley Kidney Specialists, PC to leave personal, medical information about myself at the following numbers. I understand that this option is voluntary and by checking "DECLINE," Valley Kidney Specialists, PC will only give personal, medical information to myself or my chosen personal representative.

- ❑ Cell Phone: (number) ____
- ❑ Home answering machine: (number) ____________________________________
- ❑ At work: (number) ____
- ❑ Personal Representative: (See Privacy Rule Form)
- ❑ Decline all of the above options

Signature:____ Date: _____________________

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MEDICAL HISTORY

Name: ______________________________ DOB: ______________

Please place a check next to any illnesses that apply to you.

Heart related illnesses:

❑ Chest pain (Angina)
❑ Surgery (bypass or valve replacement)
❑ Heart attack (MI)
❑ Cardiac catheterization or angioplasty
❑ High blood pressure
❑ Stroke
❑ Peripheral Vascular Disease

Pulmonary (LUNG) problems:

❑ Pneumonia
❑ Emphysema
❑ Bronchitis
❑ Cancer
❑ TB
❑ Blood clots

Gastro-intestinal illnesses:

❑ Chronic constipation / diarrhea
❑ Irritable bowel
❑ Ulcerative colitis or Crohn's
❑ Diverticulitis
❑ Bowel obstructions
❑ Gallbladder surgery or stones
❑ Gastric reflux (GERD)
❑ Ulcers
❑ Cancer
❑ Bowel surgery

Liver related illnesses:

❑ Hepatitis
❑ Cirrhosis
❑ Cancer

Kidney related illnesses:

❑ Stones
❑ Infections
❑ Kidney failure
❑ Dialysis (peritoneal or hemo)
❑ Visible blood in urine

Endocrine related illnesses:

❑ Diabetes – insulin or non insulin dependent
❑ Hypothyroid
❑ Hyperthyroid

Joint or bone related illnesses:

❑ Arthritis
❑ Osteoporosis
❑ Lupus
❑ Gout

Bleeding disorders:

❑ Chronic anemia
❑ Clotting problems
❑ Leukemia
❑ Previous blood transfusions

Skin disorders:

❑ New rash
❑ Rash that comes & goes
❑ Cancer

Eye disorders:

❑ Diabetic retinopathy
❑ Glaucoma
❑ Eye surgery / laser treatment

Family history of Kidney Disease:

❑ Stones
❑ Kidney Failure
❑ Dialysis / Transplant

Social history:

❑ Smoker
❑ Alcohol use
❑ Illicit drug use

Surgeries (please list): ______________________________

____

____

____

PLEASE COMPLETE AND BRING TO YOUR APPOINTMENT

MEDICATION HISTORY

Please list all of the medications (both prescription and non-prescription medications) that you are currently taking:
For example, do you take medications such as Motrin, Ibuprofen or, Advil?

Medication	Dose	How often

Please list any vitamins / supplements that you are currently taking:

____

Please list any allergies that you have:

____

HOSPITALIZATION HISTORY

Please list your most recent hospitalizations:

When: ____

Where: ____

Why: ____

PHYSICIAN HISTORY

Please list the complete name of all the physicians that you currently see:

Physician	Phone Number

PLEASE COMPLETE AND BRING TO YOUR APPOINTMENT

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PRIVACY RULE

This form allows you (the patient) to give Valley Kidney Specialists, PC authorization to disclose your protected health information (PHI) to your Personal Representative. The information covered by this authorization is protected health information, including identification of treating providers of care, diagnosis, procedures, and personal information, such as your date of birth and mailing address.

Each adult family member, including each adult child (age 18 or older or as determined by state law) who wishes to name a Personal Representative must complete an authorization form. For example, if you expect your spouse to call us on your behalf, you need to fill out this form. You are not required to name a Personal Representative, but if you do not, we will not release your protected health information to someone who may call or write on your behalf. Your Personal Representative may be anyone of your choosing, such as spouse, parent, child, friend, etc. You must provide the information requested for each person before we can treat that person as your representative.

Please note: This authorization does not give your Personal Representative authority, either implied or direct, regarding medical treatment, or direct medical care decisions.

I authorize Valley Kidney Specialists, PC to treat the person(s) named as my Personal Representative(s) subject to the restrictions named.

Patient Name: ____ Date of Birth: ____________________

Daytime Phone: ____

I understand that Valley Kidney Specialists, PC will not disclose my personal health information, except for the purpose of treatment, payments, and health care operations, or as required by law, without my written authorization. For this reason, I authorize you to disclose my protected health information to the person(s) named for the purpose of assisting with or facilitating the payment of my health plan benefits. I understand my Personal Representative is not bound by federal or state privacy laws, and may disclose my protected health information without my authorization. I acknowledge that my authorization is voluntary.

I understand that I have the right to limit the information you release under this authorization. For example, I may limit a Personal Representative's access to information only about a particular provider or diagnosis/disease. Any such limitations must be described in Restrictions.

OVER →

Personal Representative #1

Full Name:______________________________ Phone Number: ____________________

Relationship to You: ____

Restrictions: ____

____

____

Personal Representative #2 (Optional)

Full Name:______________________________ Phone Number: ____________________

Relationship to You: ____

Restrictions: ____

____

____

Personal Representative #3 (Optional)

Full Name:______________________________ Phone Number: ____________________

Relationship to You: ____

Restrictions: ____

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I understand that I do not have to name any person as my Personal Representative. I understand that I have the right to revoke or end this authorization at any time by giving written notice of my decision. I understand that my withdrawal of this authorization will not affect any action that Valley Kidney Specialists, PC has taken or information that Valley Kidney Specialists, PC has released, based upon your prior authorization.

I, ______________________________, have had full opportunity to read and consider the content of this form. I understand that by signing this form, I am confirming my authorization that Valley Kidney Specialists, PC may disclose my protected health information to the person(s) named on this form, for the purpose described above.

Patient Signature: ____ Date: ____________________

PLEASE COMPLETE AND BRING TO YOUR APPOINTMENT