KIDNEY CENTER OF CENTRAL GEORGIA, LLC

PATIENT INFORMATION

LAST NAME:_____ FIRST NAME:_____ MI:___

SSN: ___-___-___ □ MALE □ FEMALE DATE OF BIRTH:___/___/____ AGE:_____

□ SINGLE □ WIDOWED □ DIVORCED □ MARRIED SPOUSE'S NAME:_____

ADDRESS: _____ SPOUSE DOB:__/___/____ SS#:_____

CITY: _____ STATE:_____ ZIP:_____ SPOUSE EMPLOYER:_____

EMAIL:_____ SPOUSE WORK PHONE (____) ____-____

HOME PHONE (____) ____-_____ SPOUSE CELL PHONE (____)____-_____

CELL PHONE (____) ____-_____ EMERGENCY CONTACT INFORMATION

WORK PHONE (____) ____-_____ NAME:_____

EMPLOYED BY:_____ RELATIONSHIP:_____

EMP. ADDRESS:_____ PHONE: (____)_____-_____

INSURANCE INFORMATION

*****PLEASE GIVE INSURANCE CARDS AND ID TO THE RECEPTIONIST*****

PRIMARY	SECONDARY
INS. CO:_____	INS. CO:_____
POLICY #_____ GROUP#_____	POLICY #_____ GROUP#_____
RELATIONSHIP: □ SELF □ SPOUSE □ CHILD □ OTHER	RELATIONSHIP: □ SELF □ SPOUSE □ CHILD □ OTHER
INSURED NAME:_____	INSURED NAME:_____
DOB:_____ SS#:_____	DOB:_____ SS#:_____

AUTHORIZATIONS

- I hereby authorize and request the appropriate medical treatment necessary for the care of the above-named patient.
- I authorize release of ALL medical records and appeals to the referring and family physicians, and to my insurance company as applicable. I also allow fax transmittal of said records.
- I acknowledge full financial responsibility for services rendered by KCCG,LLC. I understand payment is due at time of service, unless other financial arrangements have been made prior to treatment. I understand that I am responsible for any un-met deductibles or co-insurances due.
- I understand that I must confirm which laboratory is under contract with my insurance company, and disclose this information to the staff to arrange for lab services outside of the office setting.
- I further authorize and request that my insurance payments be made directly to KCCG,LLC for services rendered.

I have read and fully understand to above consent for treatment, release of medical information, insurance authorization, and financial responsibility.

_____ _____ _____

PATIENT/POA SIGNATURE PRINT PATIENT/ POA NAME DATE

Current Medications List

Name: _____ **Emergency Contact Name/Phone:** _____

Prescription Medications:

Name of Medication	Strength and Frequency	Condition Medication Taken For	Physician who Prescribed Med	Notes

List of Other Doctors/ Providers

Please list ALL other doctors that you see on a routine basis:

1. Primary Care Doctor _____
2. Cardiologist (heart) _____
3. Pulmonologist (lungs/ breathing) _____
4. Surgeon (please specify type)_____
5. Surgeon (please specify type)_____
6. Gastro (stomach) _____
7. Urologist _____
8. OB/GYN (lady doctor)_____
9. Infection/ Wound _____
10. Others _____

What pharmacy do you use?_____number_____.

Do you have home health services? Yes No

If yes, what types of care do they provide to you?_____

_____

Name_____

KIDNEY CENTER OF CENTRAL GEORGIA

SIMPLE HISTORY/ INTAKE FORM

Social Habits:

PLEASE ANSWER THE FOLLOWING QUESTIONS:

ALLERGIES	
SMOKING	Yes / No How often?
ALCOHOL USE	Yes / No How often?
DRUG USE	Yes / No How often?

Surgical History: Please circle any of the following procedures that you have had.

HEART CATH	HYSTERECTOMY	C-SECTION	COLON RESECTION	KNEE REPLACEMENT
HEART BYPASS	TONSILECTOMY	THYROIDECTOMY	PARATHYROIDECTOMY	HIP REPLACEMENT
APPENDECTOMY	EYE LASER SURGERY	LEG BYPASS	CATARACT REMOVAL	KIDNEY REPLACEMENT
GALL BLADDER	TUBAL LIGATION	NEPHRECTOMY		

* Please list any other surgeries: _____

Hospitalizations: When was your last hospital Admission? _____

Why? _____

Family History: Please check ALL that apply.

	ALIVE/ DECEASED	HIGH BLOOD PRESSURE	DIABETES	HEART DISEASE	KIDNEY STONES	KIDNEY DISEASE/ HD	STROKE	CANCER
FATHER	A D							
MOTHER	A D							
CHILDREN	A D							
SIBLINGS	A D							

Please list any concerns or issues that you would like to discuss with the Doctor today:

NAME: _____

KIDNEY CENTER OF CENTRAL GEORGIA

657 HEMLOCK ST. STE. 200
MACON, GA 31201
TELEPHONE: (478) 254.7353
FAX: (478) 254.7350

New federal regulations (HIPAA laws) require us to have your permission to discuss your personal health information (PHI) or treatment plans with other than yourself. Please list those persons who are ALLOWED to call to obtain PHI or treatment information on the form, unless in an emergency situation.

PLEASE REVIEW THE INFORMATION BELOW AND SIGN:

I hereby give my consent to Dr. Mufid Othman, Dr. Ihab Zaggout, Dr. Franklin Fuenmayor-Cardozo, and their respective staff to review and discuss my PHI (diagnoses, laboratory results, test results, pathology reports, medication changes, etc), medical treatment, and personal or financial information with the following persons OTHER THAN MYSELF:

1. _____ Relationship_____ Phone_____
2. _____ Relationship_____ Phone_____
3. _____ Relationship_____ Phone_____

PATIENT SIGNATURE_____ DATE _____

I <u>DO NOT</u> WISH TO SHARE ANY TYPE OF INFORMATION WITH ANYONE OTHER THAN MYSELF.

PATIENT SIGNATURE_____ DATE _____

HIPAA RELEASE AND AUTHORIZATION

Patient's Name: _____ **Date of Birth**: _____

Address: _____
Social Security Number: Last 4 digits _____

Medical Records. I hereby authorize _____ ("Releasor") to use or disclose the following: (check one)

☐ - **ALL Medical Records**. I request the release of my complete health record, which may or may not include protected health information (PHI) and electronic protected health information (ePHI) protected under HIPAA.

Restrictions - Medical information relating to diagnosis and treatment of alcohol or drug abuse, mental illness, STDs, or HIV/AIDS shall: (check one)

☐ - Be Included.
☒ - NOT Be Included.

☐ - **Specific Medical Records**: _____

Recipient. My medical records shall be disclosed to the following individual or entity:

Name: Kidney Center of Central Ga. LLC

Address: 657 Hemlock St Ste 200 Macon Ga 31201

Phone: 478-254-7353 **Fax: 478-254-7350**

Purpose of Release: **Continuation of Care**

Expiration. This authorization expires on: **Will not expire**

I understand that signing this authorization is voluntary and that my treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon whether I sign this authorization.

I understand that I have the right to revoke this authorization at any time by writing to the Releasor, except where uses or disclosures have already been made based upon my original permission.

I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by HIPAA.

I will receive a copy of this authorization after I have signed it. A copy of this authorization is as valid as the original.

_____

Signature **Date**