PEACHTREE NEPHROLOGY, P.C.

NEW PATIENT INFORMATION

Date _____

Name _____ SS#_____
First Middle Last

Address_____ Email_____
Number Street P.O. Box, Apt. or Ste. #

_____Phone#_____Work#_____
City State Zip Code

Date of Birth_____Sex_____Marital Status_____ Referring Physician _____

GUARANTOR INFORMATION *(policyholder or person responsible for payment of account)*

Name_____ Phone#_____

Address _____
Number Street P.O. Box, Apt. or Ste. #

_____
City State Zip Code

PHARMACY

Pharmacy Name _____Phone# _____Fax# _____

Address _____

IN CASE OF EMERGENCY PLEASE NOTIFY:

Name_____ Relationship to Patient _____

Address _____Phone#_____

HIPAA controls how to protect health information of our patients can be discussed and with whom. This disclosure authorizes me and my staff to discuss your personal health with those you have listed below:

Name	Relationship

Name/Relationship to patient:

What kind of inforamtion can be disclosed:

☐At the doctors discretion Diagnosis ☐Treatment ☐Only return a call message ☐Medical history ☐Surgical information ☐Billing

Peachtree Nephrology, P.C. requests consent to use and disclose protected health information (PHI) for treatment, payment, and health care operations (TPO), with the right for the individual to review the Notice of Privacy Practices before signing. The center reserves the right to update the notice at any time. With consent the practice may communicate via phone, email, or mail for purposes related to TPO, but individuals have the right to request restrictions on the use or disclosure of their PHI, to which the practice is not obligated to agree, but will be bound by any agreed-upon restrictions when it does.

■ I am responsible for providing Peachtree Nephrology with accurate insurance information, updating it as necessary, obtaining and updating my referrals, and agreeing to pay for services not covered by my insurance plan while authorizing the payment of benefits to Peachtree Nephrology and assuming responsibility for my portion of the costs.

Signed:_____ Date:_____

■ I authorize payment of benefits to Peachtree Nephrology, P.C to release or obtain medical information for treatment, healthcare operations, payment or process my insurance claim, and I acknowledge I have been provided a notice of privacy practices, and agree with the HIPAA disclosure.

Signed:_____ Date:_____

Our notice of Healthcare Privacy Practices is posted in our office. We ask that you read our notice and sign an acknowledgement. A paper copy will be provided if requested.

PEACHTREE NEPHROLOGY, PC

PAST MEDICAL HISTORY

Name _____ Date _____

A. Have you ever been told by a physician that you had any of the following illnesses?

	Yes	No	Suspected	Age First Occurrence
Hepatitis				
Kidney Stone				
Pneumonia				
Diabetes				
Rheumatic Fever				
Stroke				
UTI				
Cancer				
Coronary Heart Disease (Heart Attack)				
Hypertension (High Blood Pressure)				
DVT				
Anemia				
Rheumatoid Arthritis/or Osteoarthritis				
Gout				
Thyroid disease (Specify diagnosis if known)				

Please list any other serious conditions for which you required treatment:

_____

B. If you have had any of the following operations, please list your approximate age at that time.

	Age
Appendectomy	
Cholecystectomy	
Tonsillectomy	
Hysterectomy	
Hernia Repair	

If you have had other surgeries or serious injuries, please list:

_____

_____

C. Have you ever been treated with X-Ray therapy or radioactive drugs for any condition?

Yes_____ No _____ If yes, please give details: _____

FAMILY HISTORY

The following applies to any blood relatives on either side including grandparents, first cousins, aunts, uncles, parents and children.

Has anyone in your family to your knowledge ever had the following:

		Relation
1.	Diabetes	
2.	Heart trouble	
3.	High blood pressure	
4.	Strokes	
5.	Hay fever or asthma	
6.	Cancer	
7.	Goiter or thyroid trouble	
8.	Crippling arthritis	
9.	Kidney disorder	
10.	Deafness	
11.	Bleeding diseases or blood diseases	
12.	Ulcer or stomach trouble	

	Age	If Living, state of health	If deceased, cause of death
Mother			
Father			
Brothers			
Sisters			
Spouse			
Children			

List all medications presently taking

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

- Do you smoke cigarettes? _____ How much? _____ For how long? _____
  If you have quit, when? _____
- Do you drink alcohol? _____ How much per day? _____ Per week? _____
  Have you ever had an alcohol problem? _____
- Do you smoke marijuana? _____ How much? _____
- Have you ever had drug problems? _____
- Are you allergic to any drugs, medications or X-ray material?
  _____
- Do you have any other allergies? _____