Tarrant Nephrology Associates

Patient Information

Patient Name: _____ DOB: _____

Last First MI

Home Address: _____

City: _____ State: _____ Zip: _____

Home#: _____ Cell#: _____ Alt#: _____

SS#: _____ Male: ____ Female: ____

Circle one:
Marital Status: Married Single Divorce Widow Partner Legally Separated

Primary Care Physician: _____

Last Name First Name

Employer Name: _____ Work#: _____

Circle One:
Employment Status: Full-time Part-time PRN Student Status: Full-time Part-time N/A

Emergency Contact: _____ Phone#: _____

Relationship to the patient: _____

Power Of Attorney: _____ Phone#: _____

Insurance #1: _____ Phone#: _____

Claims Address: _____

Policy#: _____ Insured DOB: _____

Insured's relationship to patient: _____

Insurance #2: _____ Phone#: _____

Claims Address: _____

Policy#: _____ Insured DOB: _____

Insured's relationship to patient: _____

Insurance #3: _____ Phone#: _____

Claims Address: _____

Policy#: _____ Insured DOB: _____

Tarrant Nephrology Associates

Insured's relationship to patient: _____

Email Address: _____

Circle one of the following in each category:

Race	**Ethnicity**	**Language**
American Indian or Alaskan Native	Hispanic or Latino	English
Asian	Not Hispanic or Latino	Other
Native Hawaiian or Other Pacific Islander	Refused to report	Indian
Black or African American		Spanish
White		Russian
Hispanic		
Other race		
Other Pacific Islander		
Refused to report		

Translator needed: Yes _____ No _____

Pharmacy Name:

_____

Phone#: _____

Address: _____

I, the undersigned, hereby authorize payment directly to Tarrant Nephrology Associates for medical services rendered. I understand I am financially responsible for all charges not covered or authorized by my insurance company.

Printed Name: _____

Signature: _____ Date: _____

** Please be advised that you will be required to complete this form at your first office visit of each year. The information you provide is updated yearly and ensures we have accurate information to file a claim on your behalf.

Thank you for your assistance with this process.

Tarrant Nephrology Associates

Phone: (817) 877-5858
Fax: (817) 335-4418

1001 Pennsylvania Ave.
Fort Worth, TX 76104

Acknowledgment of Privacy Practices

According to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), patients have certain rights to privacy regarding their protected health information. By signing below you, the patient, acknowledge the following regarding the management of your protected health information. Your protected health information will be used to:

- Conduct, plan and direct treatment by the physicians employed by Tarrant Nephrology Associates and will be shared in cooperation with healthcare providers who are involved in your care directly or indirectly.
- To obtain payment from third party payers
- To conduct normal healthcare operations such as quality assessments and physician certifications.

By signing below you agree that you have either received or waived your right to receive the Notice of Privacy Practices, containing a complete description of the uses and disclosures of protected health information. You understand that this organization has the right to change its Notice of Privacy Practices at any time. You also understand that you may request from this organization a current copy of the Notice of Privacy Practices.

I understand that I may revoke this consent in writing at any time, except to the extent that Tarrant Nephrology Associates has previously released relying on this consent.

1. Do we have permission to leave a detailed message regarding any appointments, treatments or test results at any of the following numbers we have on file for you:
   Home: __Yes __No **Cell**: __Yes __No **Work**: __Yes __No

2. Do we have permission to leave a call back number at any of the following numbers we have on file for you:
   Home: __Yes __No **Cell**: __Yes __No **Work**: __Yes __No

3. Do we have permission to mail detailed information regarding appointments, treatments or test results to your home address:
   __Yes __No

4. Do we have permission to email detailed information regarding appointments, treatments or test results to the email address you have provided us with:
   __ Yes __No __N/A

Please list anyone you give us permission to discuss your medical records with:

NAME	RELATIONSHIP	CONTACT NUMBER

Tarrant Nephrology Associates

Patient's Signature: _____ Date: _____

Authorization to Release Health Care Information

Please read this entire form before signing and complete all the sections that apply to your decisions relating to the disclosure of protected health information. Covered entities as that term is defined by HIPAA and Texas Health & Safety Code § 181.001 must obtain a signed authorization from the individual or the individual's legally authorized representative to electronically disclose that individual's protected health information. Authorization is not required for disclosures related to treatment, payment, health care operations, performing certain insurance functions, or as may be otherwise authorized by law. **Covered entities may use this form or any other form that complies with HIPAA, the Texas Medical Privacy Act, and other applicable laws.** Individuals cannot be denied treatment based on a failure to sign this authorization form, and a refusal to sign this form will not affect the payment, enrollment, or eligibility for benefits.

Patient Name: _____ D.O.B.: _____ SSN: _____

Previous Name: _____ I request and authorize

_____

To release the medical records of the patient named above to:
Tarrant Nephrology Associates
1001 Pennsylvania Ave.
Fort Worth, TX 76104
817-877-5858
This request and authorization applies to:

WHAT INFORMATION CAN BE DISCLOSED? Complete the following by indicating those items that you want disclosed. The signature of a minor patient is required for the release of some of these items. If all health information is to be released, then check only the first box.

____ All health information ____History/Physical Exam ____Past/Present Medications ____Lab Results ____Physician's Orders ____Patient Allergies____ Operation Reports ____Consultation Reports ____Progress Notes ____Discharge Summary ____Diagnostic Test Reports ____Billing Information ____Other_____

Your initials are required to release the following information:

_____Mental Health Records (excluding psychotherapy notes) _____Genetic Information (including Genetic Test Results)_____Drug, Alcohol, or Substance Abuse Records _____ HIV/AIDS Test Results/Treatment

I understand that my express consent is required to release any health care information relating to testing, diagnosis, and/or treatment for HIV (AIDS Virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use, you are specifically authorized to release all health care information relating to such diagnosis, testing or treatment.

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EFFECTIVE TIME PERIOD. This authorization is valid until the earlier of the occurrence of the death of the individual; the individual reaching the age of majority; or permission is withdrawn; or the following specific date (optional): Month _____ Day___ Year _____
RIGHT TO REVOKE: I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to the person or organization named under "WHO CAN RECEIVE AND USE THE HEALTH INFORMATION." I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected.
SIGNATURE AUTHORIZATION: I have read this form and agree to the uses and disclosures of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities as provided by Texas Health & Safety Code § 181.154(c) and/or 45 C.F.R. § 164.502(a)(1). I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws

_____ _____
Signature of Patient or Patient's Authorized Representative Date Signed

_____
Relationship or status if signed by anyone other than patient (parent, legal guardian, personal representative, etc.)

Physician List

Patient Name: _____ D.O.B.: _____

Physician/Specialist Address	**Phone & Fax Number**
_____ Cardiologist	_____
_____ Pulmonologist	_____
_____ Endocrinologist	_____
_____ Neurologist	_____
_____ Gastroenterologist	_____
_____ Hematologist	_____

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_____ _____

Urologist

_____ _____

Other

Medication List

Patient's Name: _____ D.O.B.: _____

Pharmacy: _____ Phone#: _____

Medication Name	Strength	Directions

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Patient Medical History Questionnaire (1/3)

Name: _____ D.O.B.: _____

Please indicate if you have any of the following conditions below with a **CHECK** or an **X**:

CARDIOLOGY **PULMONARY** **ENDOCRINE**

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__Hypertension
__Angina
__Heart Attack
__Heart Failure
__Atrial Fibrillation
__Irregular Heart Beat
__Heart Murmur
__Peripheral Vascular Disease
__Aortic Aneurysm

__Asthma
__Chronic Bronchitis
__Emphysema
__COPD
__Pneumonia
__Pulmonary Hypertension
__Clot in the lungs
__Sleep Apnea
__Lung Cancer

__Diabetes Type 1
__Diabetes Type 2
__Thyroid Problems
High Low
__Addison's Disease
__Cushing's Syndrome
__Pituitary Adenoma
__High Cholesterol
__Obesity

GASTROINTESTINAL

__Acid Reflux
__Ulcer Disease
__Gall Bladder Disease
__Vomiting Blood
__Blood in Stool
__GI Cancer
__Diverticulosis
__Polyps

LIVER DISEASE/PANCREAS

__Hepatitis Type _____
__Cirrhosis
__Liver Cancer
__Gallbladder Stones
__Pancreatitis
__Pancreatic Cancer

GENTIOURINARY

__Recurrent UTI
__Kidney Stones
__Chronic Kidney Disease
__Nephritis
__Prostate Problem
__Kidney Cancer
__Bladder Cancer

HEMATOLOGY

__Anemia
__Leukemia
__Bleeding Disorder
__Blood Clots-legs
__Multiple Myeloma
__Varicose Veins
__HIV
__Sjogerns Syndrome
__Fibromyalgia

NEUROLOGY

__Neuropathy
__TIA
__Stroke
__Migraine
__Seizure
__Parkinson's Disease
__Alzheimer's/Dementia

ARTHRITIS & MUSCULOSKELETAL

__Rheumatoid Arthritis
__Osteoarthritis
__Gout
__Osteoporosis
__Osteopenia
__Lupus (SLE)
__Scleroderma

OTHER MEDICAL CONDITIONS:

_____ _____
_____ _____

MEDICATION ALLERGIES: _____

Patient Medical History Questionnaire (2/3)

Name: _____ D.O.B.: _____

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SURGERIES

	Date/Year	Surgeon's Name	Nature of Surgery
1.			
2.			
3.			
4.			
5.			

HOSPITALIZATIONS

	Date/Year	Hospital Name	Reason for hospitalization
1.			
2.			
3.			
4.			
5.			

PROCEDURES

	Date/Year	Performed By	Result
Upper GI Endoscopy			
Colonoscopy			
Biopsy (any)			

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Cardiac Stress Test			
Pap Smear			
Mammogram			

Patient Medical History Questionnaire (3/3)

Name: _____ D.O.B.:_____

FAMILY HISTORY

Please make a **CHECK** in the boxes that apply:

	STATUS (A: Alive or D: Deceased) Circle One	DIABETES	HIGH BLOOD PRESSURE	KIDNEY DISEASE	HEART DISEASE	CANCER	STROKE
FATHER	A D						
MOTHER	A D						
PATERNAL GRANDFATHER	A D						
PATERNAL GRANDMOTHER	A D						
MATERNAL GRANDFATHER	A D						
MATERNAL GRANDMOTHER	A D						
SIBLINGS:	Total A ____ Total D____						
CHILDREN	Total A____ Total D____						

SOCIAL HISTORY

	CURRENTLY USE	TYPE	FREQUENCY & AMOUNT	IF QUIT, WHEN

Tarrant Nephrology Associates

ALCOHOL USE	YES NO			
SMOKING	YES NO			
ILLICIT DRUG USE	YES NO			

Please **CIRCLE** your answer below:

MARRIED: YES NO
LIVING WITH: SPOUSE ALONE OTHER _____
FLU SHOT: YES NO
PNEUMOCOCCAL VACCINE: YES NO