

# Welcome to Cumberland Nephrology Associates

## Patient Information:

Today's Date: \_\_\_\_\_

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Address: \_\_\_\_\_ Address 2: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone #: Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

Email Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Sex: Male \_\_\_\_\_ Female \_\_\_\_\_ Race: \_\_\_\_\_

SS#: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Work Status: \_\_\_\_\_ Name of Employer: \_\_\_\_\_

Emergency Contact & Phone #: \_\_\_\_\_

Primary Doctor Name & Phone #: \_\_\_\_\_

Referring Doctor Name & Phone #: \_\_\_\_\_

**Reason for Visit:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Allergies:

(Please indicate any allergies to medications, dyes, foods, herbs, metals, latex or other substances.)

\_\_\_\_\_  
\_\_\_\_\_

## Health Maintenance:

(Please place a checkmark next to the items that you have had done in the past and the date.)

Test	Most Recent Date Done
Bone Density Scan	_____
Cholesterol	_____
Colonoscopy	_____
ECHO	_____
EKG	_____
Flu Immunization	_____
Hepatitis B Vaccine	_____
HgbA1C	_____
Mammogram	_____
Microalbumin	_____
Pneumovax Immunization	_____
PSA Test	_____
TSH	_____
Tuberculosis Test	_____
Urinalysis	_____

Patient Name: \_\_\_\_\_

## Past Medical History:

(Please place a checkmark next to any condition that you have had or are currently experiencing.)

<input type="checkbox"/> AIDS	<input type="checkbox"/> Diabetes, Type 2	<input type="checkbox"/> Lupus
<input type="checkbox"/> Abdom. Aortic Aneurysm	<input type="checkbox"/> Difficulty Urinating	<input type="checkbox"/> Melanoma
<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Diverticulitis	<input type="checkbox"/> Mental Illness
<input type="checkbox"/> Alzheimer's Disease	<input type="checkbox"/> Diverticulosis	<input type="checkbox"/> Migraine
<input type="checkbox"/> Anemia	<input type="checkbox"/> Drug Addiction	<input type="checkbox"/> Mumps
<input type="checkbox"/> Anemia of Chronic Dis.	<input type="checkbox"/> Eczema	<input type="checkbox"/> Muscle Disorder
<input type="checkbox"/> Anemia, B12 Deficiency	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Myocardial Infarction
<input type="checkbox"/> Anemia, Iron Deficiency	<input type="checkbox"/> Enlarged Prostate	<input type="checkbox"/> Night Sweats
<input type="checkbox"/> Angina	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Non-Hodgkin's Lymphoma
<input type="checkbox"/> Anorexia Nervosa	<input type="checkbox"/> Erectile Dysfunction	<input type="checkbox"/> Obesity
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Esophagitis	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Arteriosclerosis	<input type="checkbox"/> Gallstones	<input type="checkbox"/> Palpitations
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Gastroesophageal Reflux Disease	<input type="checkbox"/> Pancreatitis
<input type="checkbox"/> Arthritis, Osteo	<input type="checkbox"/> Gout	<input type="checkbox"/> Parkinson's Disease
<input type="checkbox"/> Arthritis, Rheumatoid	<input type="checkbox"/> HIV Infection	<input type="checkbox"/> Peptic Ulcer Disease
<input type="checkbox"/> Asthma	<input type="checkbox"/> Headache	<input type="checkbox"/> Peripheral Vascular Dis.
<input type="checkbox"/> Atrial Fibrillation	<input type="checkbox"/> Hearing Loss	<input type="checkbox"/> Phlebitis
<input type="checkbox"/> Atrial Flutter	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Pneumonia
<input type="checkbox"/> Ben. Prostatic Hypertrophy	<input type="checkbox"/> Heart Attack, Premature	<input type="checkbox"/> Prostate Disease
<input type="checkbox"/> Bladder Infection	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Psoriasis
<input type="checkbox"/> Bleeding Disorder	<input type="checkbox"/> Heart Failure	<input type="checkbox"/> Pulmonary Embolism
<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Bulimia	<input type="checkbox"/> Heart Valve Problem	<input type="checkbox"/> Rubella
<input type="checkbox"/> Cancer (Indicate Location)	<input type="checkbox"/> Heartburn	<input type="checkbox"/> Scarlet Fever
<input type="checkbox"/> _____	<input type="checkbox"/> Hepatitis A	<input type="checkbox"/> Seizure disorder
<input type="checkbox"/> _____	<input type="checkbox"/> Hepatitis B	<input type="checkbox"/> Shortness of Breath
<input type="checkbox"/> _____	<input type="checkbox"/> Hepatitis C	<input type="checkbox"/> Sickle Cell Anemia
<input type="checkbox"/> Cardiac Arrhythmia	<input type="checkbox"/> Hernia, Abdominal	<input type="checkbox"/> Sinusitis
<input type="checkbox"/> Carotid Artery Stenosis	<input type="checkbox"/> Hernia, Femoral	<input type="checkbox"/> Stroke
<input type="checkbox"/> Cataracts	<input type="checkbox"/> Hernia, Hiatal	<input type="checkbox"/> Stroke, Premature
<input type="checkbox"/> Cerebrovascular Accident	<input type="checkbox"/> Hernia, Inguinal	<input type="checkbox"/> Swollen Ankles
<input type="checkbox"/> Chest Pain/Tightness	<input type="checkbox"/> Hernia, Umbilical	<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> COPD	<input type="checkbox"/> Herpes Simplex	<input type="checkbox"/> Transient Ischemic Attack
<input type="checkbox"/> Cirrhosis	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Trouble Urinating
<input type="checkbox"/> Colitis	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Colon Disorder	<input type="checkbox"/> Hives	<input type="checkbox"/> Tumors
<input type="checkbox"/> Colon Polyp	<input type="checkbox"/> Hodgkin's Disease	<input type="checkbox"/> Ulcer, Duodenal
<input type="checkbox"/> Congestive Heart Failure	<input type="checkbox"/> Hypercholesterolemia	<input type="checkbox"/> Ulcer, Gastric
<input type="checkbox"/> Coronary Artery Disease	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Ulcer, Peptic
<input type="checkbox"/> Crohn's Disease	<input type="checkbox"/> Hyperthyroidism	<input type="checkbox"/> Urethritis
<input type="checkbox"/> Deep Vein Thrombosis	<input type="checkbox"/> Hypothyroidism	<input type="checkbox"/> Venous Insufficiency
<input type="checkbox"/> Dementia	<input type="checkbox"/> Immune Function Disorder	<input type="checkbox"/> Vertigo
<input type="checkbox"/> Depression	<input type="checkbox"/> Incontinence	<input type="checkbox"/> Weight Gain
<input type="checkbox"/> Dermatitis	<input type="checkbox"/> Infectious Disease	<input type="checkbox"/> Weight Loss
<input type="checkbox"/> Diabetes, Gestational	<input type="checkbox"/> Leukemia	
<input type="checkbox"/> Diabetes, Insulin Dep.	<input type="checkbox"/> Liver Disease	
<input type="checkbox"/> Diabetes, Non-Insulin Dep.	<input type="checkbox"/> Lung Disease	
<input type="checkbox"/> Diabetes, Type 1		

Patient Name: \_\_\_\_\_

**Smoking Hx:** \_\_\_\_\_

\_\_\_\_\_ Never Smoker  
\_\_\_\_\_ Former Smoker: Year/Age Started \_\_\_\_\_ Year/Age Stopped \_\_\_\_\_  
\_\_\_\_\_ Current Smoker: Year/Age Started \_\_\_\_\_ How Much \_\_\_\_\_

**Alcohol Hx:** \_\_\_\_\_

\_\_\_\_\_ Never Used Alcohol  
\_\_\_\_\_ Formerly Used Alcohol: Year/Age Started \_\_\_\_\_ Year/Age Stopped \_\_\_\_\_  
\_\_\_\_\_ Currently Use Alcohol: Year/Age Started \_\_\_\_\_ Type \_\_\_\_\_ How Often \_\_\_\_\_

**Family Hx:** (Includes parents, grandparents, siblings, children) \_\_\_\_\_

Condition	Family Member	Age Diagnosed
Cancer (Type)	_____	_____
High Blood Pressure	_____	_____
Heart Disease (Type)	_____	_____
Diabetes (Type)	_____	_____
Stroke	_____	_____
Mental Disease	_____	_____
Kidney Disease	_____	_____
Bleeding Disorders	_____	_____
Drug or Alcohol Abuse	_____	_____

**Surgery Hx:** \_\_\_\_\_

Date	Surgical Procedure
_____	_____
_____	_____
_____	_____
_____	_____

**Hospitalizations:** \_\_\_\_\_

Date	Reason Hospitalized
_____	_____
_____	_____
_____	_____
_____	_____

Do you have a living will? \_\_\_\_\_ No \_\_\_\_\_ Yes

Do you have a donor card? \_\_\_\_\_ No \_\_\_\_\_ Yes

Do you have any barriers that may impede the provider and or staff from providing medical care to you (language, visual and/or auditory deficits, physical or mental handicap, cultural/religious custom)? \_\_\_\_\_ No \_\_\_\_\_ Yes, please explain \_\_\_\_\_

Patient Name: \_\_\_\_\_

## Insurance Information

All information must be filled out entirely in order for your visit to be billed correctly to your insurance company. Without the correct information we can't bill your insurance and you will be accountable for the bill. We need the primary insurance holder's information. Ex: If you are the patient and you are covered under your spouse's insurance we need your spouse's information, also same with parent/child coverage.

\*Date of Birth and Social Security number are mandatory for billing purposes.

### **Primary Insurance:**

Name of Insured: \_\_\_\_\_

Relationship to you: \_\_\_\_\_ Self: \_\_\_\_\_ No \_\_\_\_\_ Yes

Address of Insured: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone #: \_\_\_\_\_ DOB: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Employer: \_\_\_\_\_

Phone # of Employer: \_\_\_\_\_

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### **Secondary Insurance:**

Name of Insured: \_\_\_\_\_

Relationship to you: \_\_\_\_\_ Self: \_\_\_\_\_ No \_\_\_\_\_ Yes

Address of Insured: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone #: \_\_\_\_\_ DOB: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Employer: \_\_\_\_\_

Phone # of Employer: \_\_\_\_\_

## Assignment of Benefits

I irrevocably assign to Cumberland Nephrology Associates all my rights and benefits under any insurance contracts for payment for services rendered to me by Cumberland Nephrology Associates. I irrevocably authorize all information regarding my benefits under any insurance policy relating to any claims by Cumberland Nephrology Associates to be released to Cumberland Nephrology Associates. I irrevocably authorize Cumberland Nephrology Associates to file insurance claims on my behalf for services rendered to me. I irrevocable direct that all such payments go directly to Cumberland Nephrology Associates. I irrevocably authorize Cumberland Nephrology Associates to act on my behalf and report any suspected violations of proper claim practices to the proper authorities. This assignment of benefits has been explained to my full satisfaction and I understand its nature and effect.

\_\_\_\_\_  
Signature of Patient / Responsible Party

\_\_\_\_\_  
Date

Patient Name: \_\_\_\_\_

## Authorization for Release of Medical Records

I hereby give my authorization to any hospital, physician or other facility that has treated or examined me to release any and all medical records to Cumberland Nephrology Associates. I also authorize Cumberland Nephrology Associates to release any and all medical records necessary for evaluation of my medical conditions to any hospital, physician, or other facility that is or will be treating me.

\_\_\_\_\_  
Signature of Patient / Responsible Party

\_\_\_\_\_  
Date

## Authorization to Use and Disclose Health Information

Under the Health Insurance Portability & Accountability Act of 1996, you have certain rights to privacy regarding your protected health information. This information will be used to direct treatment among healthcare providers, obtain payment from third party payers and conduct normal healthcare operations. A more complete description of these uses is included in the **Notice of Privacy Practices**.

At Cumberland Nephrology Associates, we protect your personal, health, and financial information by complying with the national standards to protect the privacy of personal healthcare information. However, our healthcare professionals may disclose, personal, health, or financial information about patients if given permission to do so and only to those in which you identify.

Please list below those persons whom you wish to have access to your personal, health, and financial information. Again, this information will only be released to those listed below:

Name

Relationship

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

My signature also gives permission to leave a message on my home/work answering machine/voice mail and my cellular phone.

I acknowledge that Cumberland Nephrology Associate's **Notice of Privacy Practices** has been made available to me and I understand that once Cumberland Nephrology Associates discloses any information to any of the above persons, that Cumberland Nephrology Associates cannot guarantee that the recipient will not re-disclose my health information to a third party. Any such third party may not be required to abide by this Authorization or applicable Federal and State Law governing the use and disclosure of my health information. I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my health information. By my signature below, I hereby, knowingly and voluntarily, authorize Cumberland Nephrology Associates to use or disclose my health information in the matter described and to those that I have designated above.

\_\_\_\_\_  
Signature of Patient / Responsible Party

\_\_\_\_\_  
Date

**TERM:** This authorization will remain in effect from the date of authorization until otherwise notified in writing.

Patient Name: \_\_\_\_\_