Regional Kidney Care

Registration Form

Account #: _____

Patient Information- PLEASE PRINT

Last Name | First | Middle | Maiden

Race: Caucasian African American American Indian Hispanic/Latino Asian Other Race: _____

Primary Language: English Other: _____

Address | City | State | Zip

Home Phone | Cell Phone | Sex | Marital Status

Date of Birth | Age | Social Security Number

Referring Physician | Primary Care Physician

Pharmacy | Address | Pharmacy Phone Number

Emergency Contact

Notify in case of Emergency | Phone Number | Relationship to Patient

Insurance Information

Primary Insurance | Policy Holder | Birth date

Secondary Insurance | Policy Holder | Birth date

Patient Signature _____ **Date** _____

Regional Kidney Care

2002 Brookside Drive, Suite 102
Kingsport, TN 37660

1 Medical Park Blvd., Suite 100 E
Bristol, TN 37620

423-245-6000 - Phone
423-245-6062 – Fax

AUTHORIZATION

Patient and/or guarantor are responsible for charges incurred. It is a courtesy for our office to file your insurance, however you are responsible for your copay and/or percentage, which the insurance company is not liable for on the day of your visit. In the event your insurance company has not paid within 60 days you are responsible for the balance due. It is also the patient's responsibility to obtain referrals from your primary care physicians when required. If the referral is not obtained before the visit, the patient is liable for payment in full on the date of service. If we are unable to obtain payment within a reasonable amount of time from the patient and/or guarantor we will place your account with a collection agency, which will leave you liable for additional expenses incurred if applicable. I _____ have fully read and understand the above statement of payment policy. I hereby request any benefits on my behalf, to be paid to the physicians. I also authorize the release of any information acquired in the course of my treatment to my insurance company as needed to issue benefits. I authorize the physicians to administer such treatment, as they may deem advisable for my diagnosis and treatment. I certify that I have been made aware of the role and services offered by the physician, physician assistant and nurse practitioner and I consent to care by such providers. I understand that these services are voluntary and that I have the right to refuse these services.

_____ _____
Signature **Date**

I authorized this facility to release information to:

Spouse: _____ Phone # _____

Child: _____ Phone # _____

Child: _____ Phone # _____

Other: _____ Phone # _____

None

_____ _____
Signature **Date**

Referring Provider: _____
Primary Care Doctor: _____
Surgical Care Doctor: _____

PAST MEDICAL HISTORY

Have you had any of these medical problems?

☐High Blood Pressure	☐Kidney or Urine Infection
☐Sugar Diabetes	☐Cysts or Tumors in Kidney
☐Heart Disease	☐Kidney Disease
☐Stroke	☐Kidney Stones
☐High Cholesterol	☐Blood in Urine
☐Lung Disease	☐Protein in Urine
☐Anemia	☐Pain or Difficulty with Urination
☐Bleeding Problems	☐Gout
☐Thyroid Diseases	☐Ankle Swelling
☐Seizures	☐Puffiness in Eyes or Face
☐Cancer	☐Arthritis
☐Hepatitis	☐Skin Rashes
☐Ulcers	☐Other:_____

SURGICAL HISTORY

☐Appendectomy	☐Hysterectomy
☐CABG	☐Nephrectomy
☐Carotid Endarterectomy	☐Renal Transplant
☐Cataract Surgery	☐Thyroidectomy
☐D&C	☐Tonsillectomy
☐Gall Bladder removal	☐Valve Replacement
☐Gastric Bypass	☐AV Fistula
☐Hemorrhoidectomy	☐AV Graft
☐Hernia Repair	☐PD Catheter
☐Hip Replacement	☐Other:_____
☐Knee Replacement	☐Other:_____

FEMALE HISTORY

Do you have regular periods? ☐Yes ☐No
Date of last period: _____
Number of pregnancies: _____
Did you have: ☐High Blood Pressure ☐Protein in Urine ☐Preeclampsia ☐Toxemia
Age of "change of life" (menopause): _____ Last Pap Smear: _____

FAMILY HISTORY

Kidney Disease: ☐Father ☐Mother ☐Sibling ☐Child

Sugar Diabetes:	☐Father	☐Mother	☐Sibling	☐Child
High Blood Pressure:	☐Father	☐Mother	☐Sibling	☐Child
Heart Disease / Heart Attack	☐Father	☐Mother	☐Sibling	☐Child
Cancer:	☐Father	☐Mother	☐Sibling	☐Child
Stroke:	☐Father	☐Mother	☐Sibling	☐Child
Gout:	☐Father	☐Mother	☐Sibling	☐Child
Dementia:	☐Father	☐Mother	☐Sibling	☐Child
Tuberculosis:	☐Father	☐Mother	☐Sibling	☐Child
Kidney Cysts:	☐Father	☐Mother	☐Sibling	☐Child
Kidney Failure:	☐Father	☐Mother	☐Sibling	☐Child
Kidney Transplant:	☐Father	☐Mother	☐Sibling	☐Child
Kidney Stones:	☐Father	☐Mother	☐Sibling	☐Child
Kidney / Urine Infections:	☐Father	☐Mother	☐Sibling	☐Child
Dialysis Treatments:	☐Father	☐Mother	☐Sibling	☐Child

Father:	☐Living	☐Deceased	☐Unknown
Mother:	☐Living	☐Deceased	☐Unknown

SOCIAL HISTORY

Current Marital Status	☐Single	☐Divorced	☐Separated	☐Widowed	☐Married
Living Arrangement	☐Alone	☐Spouse	☐Significant Other	☐Family Member	
	☐In-home Caregiver	☐Assistant Living Facility			
Occupation	☐Retired	☐Employed	☐Unemployed	☐Student	
Functional/Cognitive	☐No Impairment	☐Memory Deficit	☐Hearing Loss	☐Poor Vision or Blindness	
	☐Limited Mobility				
Tobacco Use	☐Current User	☐Former User	☐Never Used	☐Cigars	
	☐Chewing Tobacco	☐Snuff			
Frequency (Cigarettes)	☐Every day	☐Some days	☐Unknown		
	☐Packs per day: ___	☐Years smoked: ___	☐Year started: ____	☐Year quit: ____	
Alcohol Use	☐Never User	☐Current User	☐Former User		
	☐Year started: ____		☐Year quit: ____		
Recreation Drug Use	☐Never User	☐Current User	☐Former User		
	☐Year started: ____		☐Year quit: ____		

REVIEW OF SYSTEMS

Are you currently having the following symptoms?

Constitutional	☐Fever	☐Fatigue	☐Weight Gain
	☐Chills	☐Weakness	☐Weight Loss
HEENT	☐Vision Impaired	☐Eye Pain	☐Redness
	☐Color Blindness	☐Double Vision	☐Hearing Loss

	☐Ear Pain	☐Ringing in Ears	☐Dizziness
	☐Headache	☐Sore Throat	☐Hoarseness
	☐Sinus Problems	☐Nose Bleeds	
Respiratory	☐Shortness of Breath	☐Shortness of Breath at rest	☐Shortness of Breath with activity
	☐Pain with Breathing	☐Cough	☐Wheezing
	☐Coughing up blood	☐Night Sweats	
Cardiovascular	☐Chest Pain	☐Palpitations	☐Difficult to breathe on back
	☐Pain in legs when walking	☐Swelling	☐Waking at night with shortness of breath
Gastrointestinal	☐Abdominal Pain	☐Nausea	☐Vomiting
	☐Diarrhea	☐Constipation	☐Decreased Appetite
	☐Heartburn/Indigestion/Reflux	☐Trouble Swallowing	
Genitourinary	☐Urinary Urgency	☐Urinary Hesitancy	☐Urinary Burning or Pain
	☐Foamy Urine	☐Urinary Frequency	☐Incontinence
	☐Urinating at night	☐Blood in Urine	
Musculoskeletal	☐Back Pain	☐Muscle Pain	☐Neck Pain
	☐Joint Pain	☐Arm Weakness	☐Leg Weakness
Skin	☐Rash	☐Itching	☐Dryness
	☐Scaling	☐Color Change	
Neurological	☐Numbness	☐Tingling	☐Tremors
	☐Fainting	☐Seizures	
Psychiatric	☐Depression	☐Anxiety	☐Insomnia
Endocrine	☐Heat Intolerance	☐Cold Intolerance	
	☐Excessive Thirst	☐Excessive Urination	
Hematology	☐Bleeding Gums	☐Easy Bruising	
Immuno/Allergy	☐Seasonal Allergies	☐Hives	