MODERN KIDNEY & TRANSPLANT CARE

BASIC INFORMATION

First Name	Middle Initial	Last name
Male Female Sex	Date of Birth	Phone Number
Email address	Social security Number	Marital Status

Address City/State Zip code

Race	Hispanic/Latino?	Language

EMERGENCY CONTACT

First Name	Last Name	Relationship to contact

Primary Phone Number

Financial Information

Responsible Party

Who will be financially responsible for you? ___ Myself _____Someone else

If someone else please list who?

Primary Insurance Policy

Insurance Name	Policy Number

Secondary Insurance

Insurance Name	Policy Number

HEALTH HISTORY

Patient Name: _____ MR#: _____

Date of Birth: _____ Age: _____ Sex: M _____ F _____

Home Phone: _____ Work Phone: _____ Email: _____

How did you learn about Modern Kidney?

PCP _____ Specialist _____ Relative / Friend _____

Internet Search _____ Other _____

Referring Physician(s): _____ Phone: _____

_____ Phone: _____

Reason(s) for referral to this office: _____

Please list the names of all physicians you currently see:

_____ Phone: _____

_____ Phone: _____

_____ Phone: _____

_____ Phone: _____

_____ Phone: _____

_____ Phone: _____

MEDICATIONS

Your Pharmacy: _____ Phone: _____

List all medications (including dose and how often you take it):

Medication Name	Dosage	How often?

_____ _____ _____
_____ _____ _____

_____ _____ _____

Please list all over the counter medications (examples: Tylenol, Advil) herbal supplements and vitamins you currently take:

OTC Medication	Name Dosage	how often?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Known Drug Allergies: _____

PREVIOUS MEDICAL HISTORY

Do you have any of the following?

Hypertension (High Blood Pressure) Yes ____ No ____
If yes, for how long? _____
Diabetes Yes ____ No ____
If yes, for how long? _____
Heart Disease:
History of a heart attack Yes ____ No ____
If yes, when? _____
Atrial fibrillation Yes ____ No ____
Heart failure Yes ____ No ____
Pacemaker Yes ____ No ____
History of an angioplasty? Yes ____ No ____
If yes, when? _____
Any other heart conditions? Yes ____ No ___
If yes, what? _____

List any surgeries:

Surgical Procedure	Date/Year	Surgeon/Physician Name
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

List any illnesses:

Illness	Date/Year	Illness	Date/Year
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

SOCIAL / OCCUPATIONAL HISTORY

Married: _____ Single: _____ Divorced: _____ Widowed (er): _____ Separated: _____
Are you currently working? Yes ____ No ____ Your Occupation: _____
Are you working full time? Yes ____ No ____ How many hours/day? _____

Do you currently smoke? Yes ____ No ____ _____ packs per day
Have you ever smoked? Yes ____ No ____ _____ packs per day
How long have/did you smoke? _____
Have you ever used illegal drugs? Yes ____ No ____
What type of drugs have you used? _____
When did you last use drugs? _____
Do you currently consume alcoholic drinks? Yes ____ No ____
How many alcoholic drinks do you consume per day? _____ Per week? _____

FAMILY HISTORY

	Age	Medical Problems	Cause of Death/Age at death (If no longer alive)
Father	____	_____	_____
Mother	____	_____	_____
Brothers	____	_____	_____
	____	_____	_____
	____	_____	_____
	____	_____	_____
Sisters	____	_____	_____
	____	_____	_____
	____	_____	_____
	____	_____	_____
Sons	____	_____	_____
	____	_____	_____
	____	_____	_____
Daughters	____	_____	_____
	____	_____	_____
	____	_____	_____

Check if any of your blood relatives had any of the following:

Disease		**Relationship to you**
Diabetes	Yes ____ No ___	_____
Heart Disease	Yes ____ No ___	_____
Stroke	Yes ____ No ___	_____
High Blood Pressure	Yes ____ No ___	_____
Kidney Disease	Yes ____ No ___	_____
Malignancy/Cancer	Yes ____ No ___	_____

SYSTEMS REVIEW

CONSTITUTIONAL *Check any that apply to you...*

Recurrent Fevers? Yes ____ No ___
Chills or Night Sweats? Yes ____ No ___
Loss of Appetite? Yes ____ No ___
Your height is: _____ Your current weight is: _____
Is this your usual weight? Yes ____ No ____
Have you recently gained weight? Yes ____ No ____
Have you recently lost weight? Yes ____ No ____

IMMUNIZATIONS:

COVID-19? Yes _____ No _____ When received? _____
Hepatitis B? Yes _____ No _____ When received? _____
Pneumonia? Yes _____ No _____ When received? _____
Influenza? Yes _____ No _____ When received? _____
Shingles? Yes _____ No _____ When received? _____

EYE, EAR, NOSE, AND THROAT *Check any that apply to you...*

Blindness Yes ____ No ___
Glaucoma Yes ____ No ___
Diabetic Retinopathy Yes ____ No ___
Deafness/Hearing Loss Yes ____ No ___

PULMONARY (Lungs) *Check any that apply to you...*

TB/Tuberculosis/Positive TB skin test Yes ____ No ___
History of abnormal chest x-ray Yes ____ No ___
Shortness of breath Yes ____ No ___
Chronic Bronchitis Yes ____ No ___
Asthma Yes ____ No ___
Emphysema/COPD Yes ____ No ___
History of lung masses/nodules Yes ____ No ___
History of lung cancer Yes ____ No ___

CARDIAC (Heart) and **VASCULAR** (Circulation) *Check any that apply to you...*

Chest Pain Yes ____ No ___
Palpitations Yes ____ No ___
Poor Circulation Yes ____ No ___
Pain in Legs When Walking Yes ____ No ___
Ulcers on Feet Yes ____ No ___
Do you ever wake up at night short of breath? Yes ____ No ___
Do you have to sleep on extra pillows in order to breathe? Yes ____ No ___

GASTROENTEROLOGY (Abdomen/intestines/liver/stomach) *Check any that apply to you...*

Ulcer in stomach or intestines Yes ____ No ___
History of Polyps Yes ____ No ___
History of Blood in Stools Yes ____ No ___
Diverticulosis Yes ____ No ___
History of vomiting blood? Yes ____ No ___
Problems with swallowing? Yes ____ No ___
History of intestinal problems? Yes ____ No ___
Have you ever had a colonoscopy (lower endoscopy)? Yes ____ No ___
When? _____ Why? _____
Have you ever had an EGD (upper endoscopy)? Yes ____ No ___
When? _____ Why? _____

NEPHROLOGY/UROLOGY (Kidney/bladder/ureter/urethra) *Check any that apply to you...*

History of Kidney Infections Yes ____ No ___
Kidney Stones Yes ____ No ___
Polycystic kidney disease? Yes ____ No ___
History of Enlarged Prostate Yes ____ No ___
Frequent Bladder Infections Yes ____ No ___
History of Bladder Surgeries Yes ____ No ___
If yes, why? _____
Do you get up during the night to urinate? Yes ____ No ___
If yes, how many times? _____
Do you have burning when you urinate? Yes ____ No ___
Do you see blood in your urine? Yes ____ No ___
Have you been told you have protein in your urine? Yes ____ No ___

QUESTIONS FOR FEMALE PATIENTS: *Check any that apply to you...*
How many times have you been pregnant? _____
How many living children do you have? _____
How many miscarriages have you had? _____

QUESTIONS FOR MALE PATIENTS: *Check any that apply to you...*

Have you had loss of sexual interest? Yes ____ No ___
Do you have difficulty having an erection? Yes ____ No ___

MUSCULOSKELETAL *Check any that apply to you...*

Arthritis Yes ____ No ___
Joint Pain / Swelling Yes ____ No ___
Broken Bones Yes ____ No ___
Osteoporosis Yes ____ No ___

NEUROLOGY (Brain and Spinal Cord) *Check any that apply to you...*

Headaches Yes ____ No ___

Head Injury Yes ____ No ___
Seizures Yes ____ No ___
If history of seizures, please give date and cause: _____
CVA (Stroke) Yes ____ No ___
Spinal Cord Injury Yes ____ No ___

ENDOCRINOLOGY (Diabetes or Thyroid) *Check any that apply to you...*

Do you have Diabetes? Yes ____ No ___
Age when diagnosed _____
Treated with Insulin? Yes ____ No ___
Treated with Oral Agents? Yes ____ No ___
Thyroid nodule/masses Yes ____ No ___
Thyroidectomy/Thyroid surgically removed? Yes ____ No ___

HEMATOLOGY/ONCOLOGY/RHEUMATOLOGY Check any that apply to you...

History of Bleeding Problems Yes ____ No ___
History of Difficulty Clotting Yes ____ No ___
Hemophilia Yes ____ No ___
Sickle Cell Disease Yes ____ No ___
Amyloidoisis Yes ____ No ___
Systemic Lupus Erythematous Yes ____ No ___
Vasculitis Yes ____ No ___
Goodpasture's Disease Yes ____ No ___
History of swollen lymph nodes Yes ____ No ___
History of Cancer Yes ____ No ___
If yes, what type? _____
When was the cancer diagnosed? _____
What treatment was done? _____
Have you ever had a blood transfusion? Yes ____ No ___

INFECTIONS *Check any that apply to you...*

HIV Yes ____ No ___
Hepatitis B Yes ____ No ___
Hepatitis C Yes ____ No ___
Lyme disease Yes ____ No ___
Any other serious infections? Yes ____ No ___
If yes, please list: _____

PSYCHOLOGICAL (Mental/Social) *Check any that apply to you...*

History of Mental Illness Yes ____ No ___
History of Alcohol/Substance Abuse Yes ____ No ___
Anxiety Yes ____ No ___
Depression Yes ____ No ___

ADDITIONAL COMMENTS

Modern Kidney & Transplant Care

ASSIGNMENT OF BENEFITS FORM

Name of Insured (print): _____

Social Security Number: _____

I request that payment of authorized insurance benefits, including Medicare, if I am a Medicare beneficiary, be made on my behalf to Modern Kidney & Transplant Care for any medical services provided to me by that organization.

I authorize the release of any medical or other information necessary to determine these benefits or the benefits payable for related equipment or services to the organization, the Health Care Financing Administration, my insurance carrier, or other medical entity. A copy of this authorization will be sent to the Health Care Financing Administration, my insurance company or other entity, if requested. The original will be kept on file by the organization.

I understand that I am financially responsible to the organization for any charges not covered by health care benefits. It is my responsibility to notify the organization of any changes in my health care coverage. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by the organization and/or my health care insurer if the submitted claims or any part of them are denied for payment. I understand that by signing this form, I am accepting financial responsibility as explained above for all payment for products and services received.

_____

Patient Name (Printed)

_____

Relationship to Insured

_____

Signature of Insured/Parent/Guardian

_____

Date

MODERN KIDNEY & TRANSPLANT CARE PATIENT INFORMED CONSENT FOR TELEMEDICINE SERVICES AND EPRESCRIBE

MODERN KIDNEY & TRANSPLANT CARE has implemented an electronic health record (EHR) in part to meet the U.S. Department Health and Human Services initiative to improve health information technology, toward the goal of improving quality of health care. Our EHR integrates your clinical record with appointments, registration, and billing and makes this information available to the clinicians who are involved in your health care. In connection with its electronic communication systems, KAREO has also implemented and has in place privacy and security policies and procedures to minimize risk of inadvertent or unauthorized disclosure, corruption and/or loss or distortion of data, but as with all record keeping systems, whether paper or digital, some risks remain of loss, inadvertent disclosure, or errors in the recorded data. I have read and understand the information provided regarding telemedicine, have discussed it with my physician or such assistants as may be designated, and all my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telemedicine including electronic transfer of medical data to other medical practitioners participating in my medical care. I hereby authorize MODERN KIDNEY & TRANSPLANT CARE to use telemedicine in the course of my diagnosis and treatment and consent to the electronic communication of my personal health care information to other entities for treatment, payment or health care operations. INFORMED CONSENT FOR PRESCRIPTIONS MODERN KIDNEY & TRANSPLANT CARE continues its position as the network exchange for the flow of vital patient information to physicians and other health care providers. It is essential to improve patient safety and the continuity of care with electronic connectivity between payers, physicians, and pharmacists. MODERN KIDNEY & TRANSPLANT CARE electronic health record (EHR) provides secure access for patients with commercial prescription coverage in the United States. Prescription eligibility, benefit, formulary, and medication history information is provided for consenting patients to authorized physicians at the point of care. Electronic prescriptions are delivered in real-time to pharmacists in the retail and mail order settings. I consent to electronic prescriptions and acknowledge that MODERN KIDNEY & TRANSPLANT CARE will use electronic connectivity between payers, physicians, and pharmacists. PATIENT PORTAL CONSENT MODERN KIDNEY & TRANSPLANT CARE is offering the patient portal as a convenience to you. The patient portal is a secure web portal that allows you, as a patient, to view your medical chart and to access our online bill pay via the internet. It also allows you to communicate with our office via secure messaging. You may request appointments, schedule changes, and medication refills (not including controlled substances). MODERN KIDNEY & TRANSPLANT CARE reserves the right to suspend or terminate the patient portal at any time and for any reason. I understand that the patient portal will be offered at no charge and acknowledge that communications over the internet using the portal is secure. I also, agree to the policy defined herein for suspension or termination of portal access.

Signature of Patient/Legal Representative_____Date_____

Witness_____Date_____

Authorization for Release of Protected Health Information (PHI)

Type or print:

I hereby authorize _____ to release health records information on:
Name of provider

Patient Name _____ DOB _____

Address _____ Phone _____

City/State/Zip _____ SS# _____

For Healthcare Covering the Period(s) from _____ to _____

- May include other healthcare providers' records? ☐ Yes ☐ No
- May records be faxed or electronically transmitted? ☐ Yes ☐ No

This information is to be released to:

_____ _____/_____
Name of person/facility to receive information Telephone # Fax #

_____ _____
Address of person/facility to receive information City, State, Zip

Information to be disclosed: (Please initial on appropriate line.)

____Copy of all health records to **include** HIV testing/results, mental health and/or alcohol or drug abuse records
____Copy of all health records to **exclude** HIV testing/results, mental health and/or alcohol or drug abuse records
____Billing Records
____Specific records: Laboratory Tests____Progress Notes____X-Ray Reports____Other_____

It is preferable to request patients and third parties to indicate what specific parts of the record need to be disclosed so as to meet the HIPAA Privacy Rule minimum necessary standard. If the patient authorizes his or her complete designated record set (medical record) to be released to a third party, a full copy needs to be provided as the patient authorized.

The purpose of this disclosure is for:

☐ Continuance of Medical Care ☐ Attorney ☐ Insurance
☐ Other _____

I understand that the information released as a result of this Authorization may be subject to re-disclosure and no longer protected by federal or state laws applying to medical information release.

I understand that there may be a fee for copying of my medical records if it is to be used for other than continuance of healthcare with another provider.

I understand that this Authorization may be revoked in writing at any time. I understand that revocation will apply only to releases of information made after the date of my revocation.

Unless otherwise indicated, this authorization will expire twelve months (12) from the date of signature. A photocopy of this authorization will be considered as valid as the original. I understand that I will be provided a copy of this Authorization upon request. I understand that I may request a copy of the information to be disclosed.

I understand and agree that my medical record will be maintained in an electronic medical record (EMR) format and that records may be transmitted electronically via fax, E-mail, Internet, or data transfer system.

I understand that DNA cannot require me to sign this Authorization as a condition to providing services to me. I understand disclosure is voluntary. I understand that if I have any questions about this disclosure, I may contact my physician or DNA Privacy Officer.

_____ _____
Signature Date

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

Revised 3.18

Modern Kidney & Transplant Care

Name: _____ Date: _____

Temperature: _____

COVID-19 QUESTONNAIRE

4. In the last 14 days, have you experienced any of the following symptom's fever at least 100.4 degrees, felt feverish, cough, shortness of breath or sore throat? ___ Yes ____ No

5. Have you been in contact with individuals confirmed with Coronavirus, quarantined for suspected Coronavirus, or experiencing Coronavirus symptoms? ___ Yes ____ No

6. Have you traveled anywhere outside of the United States or to a Coronavirus outbreak area within the last 14 days? ___ Yes ____ No

Modern Kidney & Transplant Care

Name: _____ Date: _____

Temperature: _____

COVID-19 QUESTONNAIRE

1. In the last 14 days, have you experienced any of the following symptom's fever at least 100.4 degrees, felt feverish, cough, shortness of breath or sore throat? ___ Yes ____ No

2. Have you been in contact with individuals confirmed with Coronavirus, quarantined for suspected Coronavirus, or experiencing Coronavirus symptoms? ___ Yes ____ No

3. Have you traveled anywhere outside of the United States or to a Coronavirus outbreak area within the last 14 days? ___ Yes ____ No