1. PATIENT DEMOGRAPHICS

First Name * M.I. Last Name *

Date of Birth *

Gender *

☐ Female ☐ Male

Marital Status *

☐ Single ☐ Married ☐ Domestic Partner

☐ Separated ☐ Divorced ☐ Widowed

Street Address * Apt #

City * State * Zip Code *

Home Phone Mobile Phone

Preferred Contact Method *

☐ Mobile Phone ☐ Home Phone ☐ Email

Email Address * Social Security Number

Driver's License Number Occupation

Race (check all that apply)

☐ White ☐ Black/African American ☐ Asian ☐ American Indian

☐ Alaska Native ☐ Native Hawaiian ☐ Pacific Islander

Ethnicity

☐ Hispanic or Latino ☐ Non-Hispanic or Latino

2. PRIMARY INSURANCE

Insurance Company *

Member ID / Policy # *

Group Number

Relationship to Insured *

☐ Self ☐ Spouse ☐ Child ☐ Other

Complete the following if you are NOT the insured:

Insured Name (First and Last)

Insured Phone #

Insured Date of Birth

Insured Gender: ☐ Female ☐ Male

Insured SSN

Insured Employer

Insured Address

City

State

Zip

3. SECONDARY INSURANCE (if applicable)

Insurance Company

Member ID / Policy #

Group #

Relationship to Insured

☐ Self ☐ Spouse ☐ Child ☐ Other

4. EMERGENCY CONTACT

Full Name *

Relationship *

Phone Number *

5. PATIENT MEDICAL HISTORY

Preferred Pharmacy (Name and Address)

Preferred Laboratory Service

☐ Sonora Quest Labs ☐ LabCorp ☐ CCL (Central Labs)

☐ Express Labs ☐ Unique Labs

Primary Care Physician

Referring Physician

ALLERGIES

☐ NO KNOWN DRUG ALLERGIES

If you have allergies, please list them below:

Medication	Reaction

CURRENT MEDICATIONS

List all daily medications including over-the-counter vitamins and supplements:

Medication Name	Dosage	Frequency

Current Medications (continued)

Medication Name	Dosage	Frequency

MEDICAL HISTORY - Have you ever been diagnosed with any of the following?

- ☐ Acute Kidney Injury
- ☐ Anemia
- ☐ Atrial Fibrillation
- ☐ Cancer
- ☐ CHF (Heart Failure)
- ☐ Chronic Kidney Disease
- ☐ Clotting Disorder
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Diabetes Mellitus
- ☐ Diabetic Neuropathy
- ☐ End Stage Renal Disease
- ☐ Enlarged Prostate
- ☐ GERD/Acid Reflux
- ☐ Gout
- ☐ Hematuria
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ HIV/AIDS
- ☐ Hyperkalemia

Medical History (continued)

- ☐ Hyperlipidemia
- ☐ Hypertension
- ☐ Hypothyroidism
- ☐ Lupus
- ☐ Nephrotic Syndrome
- ☐ Osteoporosis
- ☐ Proteinuria
- ☐ Renal Cyst
- ☐ Stroke
- ☐ UTI
- ☐ Hyperparathyroidism
- ☐ Hyponatremia
- ☐ Kidney Stones
- ☐ Myocardial Infarction
- ☐ Osteoarthritis
- ☐ Polycystic Kidney Disease
- ☐ Pyelonephritis
- ☐ Sleep Apnea
- ☐ TIA
- ☐ NONE of the above

If Cancer or other conditions, provide details (type, year):

SURGICAL HISTORY

☐ NO KNOWN SURGERIES
Please list any major surgeries:

Type of Surgery	Year/Date	Physician

FAMILY HISTORY - Indicate if immediate relatives have had the following:

Disease	Mother	Father	Siblings
Anemia	☐	☐	☐
Autoimmune Disease	☐	☐	☐
Cancer	☐	☐	☐
Diabetes	☐	☐	☐
Hypertension	☐	☐	☐
Kidney Disease	☐	☐	☐
Stroke	☐	☐	☐
Heart Disease	☐	☐	☐
Dementia	☐	☐	☐
Gout	☐	☐	☐
Polycystic Kidney Disease	☐	☐	☐

SOCIAL HISTORY

Do you smoke? ☐ Yes ☐ No Former Smoker? ☐ Yes ☐ No

Type:

☐ Cigarettes ☐ Chew ☐ Pipe ☐ Marijuana

Packs per day _____ Years smoked _____

Do you drink alcohol? ☐ Yes ☐ No

If yes, how often?

☐ Daily ☐ Weekly ☐ Rarely ☐ Social Drinker ☐ Recovering

Substance abuse history? ☐ Yes ☐ No If yes, preferred drug: _____

Whom do you reside with?

☐ Live Alone ☐ Spouse ☐ Significant Other
☐ Family Member ☐ In-Home Caregiver ☐ Assisted Living

Functional/Cognitive Concerns

☐ Impairment ☐ Memory Deficit ☐ Hearing Loss
☐ Poor Vision ☐ Limited Mobility ☐ Transportation Issues

6. HIPAA PATIENT QUESTIONNAIRE

Authorized Contacts

List persons whom we may inform about your medical condition and diagnosis:

Name	Relationship	Phone Number

Emergency-Only Contacts

List persons we may contact ONLY IN AN EMERGENCY:

Name	Phone Number

Billing Address

☐ Same as home address

Alternative Address (if different):

Street Address _____ City _____

State _____ Zip Code _____

Communication Preferences

Phone/email for appointments, lab results, and health information:

Phone Number _____ Email Address _____

Can confidential messages be left on your voicemail?

☐ Yes ☐ No

I understand the Privacy Protection Act and have been offered a copy of the Organization's Notice of Privacy Practices updated for the HITECH Omnibus Rule of 2013.

7. CONSENT FOR MEDICAL TREATMENT

I hereby authorize Desert Kidney Associates, PLC and/or such assistants as may be requested by said physician to perform the above noted medical treatment as explained to me. I hereby acknowledge and agree that if my insurance does not cover the treatment authorized above, I will be personally responsible for paying the financial charges for those services.

I understand that this medical treatment is not without risks. The benefits and risks have been explained to me. Potential risks include but are not limited to infection, bleeding, scar tissue formation, and discomfort at site.

I accept the treatment recommendation of my physician. I acknowledge that no warranty or guarantee has been made as to the results of this treatment. I understand that any aspect of this consent form that I do not understand can and will be explained to me in further detail by asking my physician.

I further certify that my physician has informed me of the nature and character of the proposed treatment, of the anticipated results, possible alternative treatment choices, and the possible risks, complications, and anticipated benefits involved in the proposed treatment, including non-treatment.

Patient Signature: _____ **Date:** _____

8. NO-SHOW FEE POLICY

ATTENTION DESERT KIDNEY PATIENTS:

Effective 10/15/2022, Desert Kidney Associates, PLC will implement a no-show fee of $50.00. This charge will be added to your account if your appointment is not cancelled within 24 hours prior to your scheduled appointment time.
Thank you for your understanding.

☐ I understand and agree to the no-show fee policy

Patient Signature: _____ **Date:** _____

9. CERTIFICATION

☐ I hereby certify that, to the best of my knowledge, the provided information is true and accurate.

Patient Name (Print): _____

Date of Birth: _____

Patient Signature: _____ **Date:** _____