COBB NEPHROLOGY/HYPERTENSION ASSOCIATES, P.C.

IMPORTANT INFORMATION

1. **Please have enclosed paperwork completed prior to arriving for your appointment. Failure to do so may result in a delay in your appointment, or you may have to be rescheduled.**
2. If you are a new patient in our office, **please arrive 30 minutes before your appointment time** so that we may prepare your chart for your visit.
3. Please bring all medical records from your referring or primary care physician related to your upcoming visit. If you do not have a copy of your medical records, please contact your primary care or referring physician and request that your medical records be faxed or mailed to our office at the address above. **Please call our office (678-460-2700) the day before your appointment to make sure your medical records have been received.** Failure to do so may cause a delay in your appointment time, or you may have to reschedule.
4. You must **bring your Insurance Card and photo identification with you** to your visit. If you fail to bring your Insurance Card, we will not be able to file your insurance on your behalf and you will be asked to pay in full for your visit that day.
5. If your insurance requires a referral from your Primary Care Physician, you must make sure that you have a valid referral prior to your visit. **Failure to have a valid referral will require you to pay for your visit in full, or you will need to be rescheduled.**
6. All patients are required to pay their insurance co-payment and any past due balance on their account at check-in. **If you need to make payment arrangements on a past due balance, please contact our billing department (678-460-2700) prior to your visit.**

CHARGES FOR ADMINISTRATIVE SERVICES REQUESTED BY PATIENT

Due to the high volume of patient requests, effective April 18, 2008, we implemented a policy and charges for completion of forms. In order to assist you, please be advised of the following administrative charges for patient requests to complete forms.

I. **FORMS**:
   - i. The charge to complete a **HANDICAP STICKER** FORM is **$10.00 PER FORM**.
   - ii. THE PATIENT REQUESTING COMPLETION OF THE FORM(S) IS RESPONSIBLE FOR THE CHARGE(S) AND MUST PAY IN FULL **PRIOR** TO THE COMPLETION OF THE FORMS(S) BY THE PRACTICE.
   - iii. **COBB NEPHROLOGY DOES NOT COMPLETE DISABILITY FORMS.**

II. **ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY FOR CHARGES**: I UNDERSTAND THAT, AS A SERVICE TO ITS PATIENTS, COBB NEPHROLOGY/ HYPERTENSION ASSOCIATES, P.C. WILL ASSIST ME WITH COMPLETION OF THE FORMS UPON MY WRITTEN REQUEST AND PAYMENT OF CHARGES.

PLEASE READ CAREFULLY AUTHORIZATION / RESPONSIBILITY AGREEMENT

All charges are due at the time of services. Necessary forms will be given to the patient to send to their insurance company. The patient is responsible for all fees, regardless of insurance coverage. I hereby authorize Cobb Nephrology / Hypertension Associates, P.C, to release any medical information to my insurance company concerning my treatment.

I acknowledge and understand that I am financially and legally responsible for all charges for all services rendered to me. Although I may request the doctor to bill my insurance company on my behalf, I clearly understand that it is my responsibility to make sure the bill is paid in a reasonable time. If for any reason any portion of my bill is not paid by my insurance company, I further agree to make arrangements for prompt payment of the bill.

HMO and POS Insurance ONLY - Members ONLY. I understand the protocol of my insurance. I understand that I require a referral from my primary care physician. **If I fail to obtain a required referral, I understand that I am financially liable for services rendered and must pay for these services at the time they are rendered.**

- **I understand that I am responsible for any deductibles, co-pays and any charges not covered by my insurance.**
- **I understand that I am required to promptly notify Cobb Nephrology Hypertension Associates, P.C. of any insurance changes and I will be financially responsible for failure to do so.**

FINANCIAL POLICY

Cobb Nephrology/Hypertension Associates, P.C. is committed to meeting your health care needs. Our goal is to keep your insurance, or other financial arrangements as simple as possible. In order to accomplish this in a cost-effective manner, we ask that you adhere to the following guidelines:

1) Payment is expected at time of service.
2) We will file your insurance for you if we are a participating provider of your plan. You will be responsible for any and all services in excess of your insurance limits as well as all non-covered services.
3) All co-payments are due at the time of service.
4) If we are not participating providers of your plan, full payment is due at the time of service, unless prior arrangements have been made. [Please confirm your insurance at the time you schedule your appointment].
5) If you are not covered by insurance, payment is expected at time of visit unless prior arrangements have been made with our business office.
6) We will mail to you a monthly billing statement for any outstanding balances.

I understand the above payment guidelines. I accept financial responsibility for payment.

_____ _____ Date: _____

Patient Signature Print Patient Name

_____ _____ Date: _____

Staff Member Signature Print Staff Member Name

COBB NEPHROLOGY/HYPERTENSION ASSOCIATES, P.C.

PATIENT AUTHORIZTION AND FINANCIAL RESPONSIBILITY FORM

By signing the Patient Authorization and Financial Responsibility Form ("Form"), I understand that I am personally responsible for the payment of all services rendered by Cobb Nephrology/Hypertension Associates, P.C. ("the Practice") to you that I may receive at the Practice. The Practice's usual and customary fees are available for my review upon request. My financial responsibility for my treatments shall continue until my primary and (if applicable) secondary insurance carrier reimburse The Practice for such services.

In return for the Practice's treatment and services, I agree to the following:

1. **Authorization**. I authorize Cobb Nephrology/Hypertension Associates, P.C. to obtain my insurance and financial information and my insurer/payor (including agents, administrators, or representatives), such as benefits and coverage information. I also authorize The Practice to release my confidential medical information to my insurer/payor (including copies of medical records) when necessary, for these or related insurance claims.
2. **Insurance Payment**. I agree to assist the Practice in any way possible in obtaining treatment authorization and payment for my treatment from my insurance carrier and/or government program. I agree to apply for benefits under any federal or state programs (including Medicare, Medicaid, state kidney fund programs, etc.) and secondary insurance plans, for which I may be eligible. I agree to furnish all information, including medical records and/or personal financial information, as may be required by Cobb Nephrology/Hypertension Associates, P.C. from time to time.
3. **Medicare (for Medicare beneficiaries only)**. I certify that the information contained in my application for benefits under Title XVII of the Social Security Act (the Medicare program) is true and correct. I authorized any holder of medical or other information about me to release to the Social Security Administration, or its intermediaries or carriers, any information needed for any Medicare claims.
4. **Treatment Authorization**. I understand that if a treatment authorization is required by my insurer or payor and the Practice cannot obtain it by the time of my office visit the Practice will require that I pay in cash prior to receiving any services or make prior payment arrangements with the business office of the Practice.
5. **Assignment of Benefits; Lien**. I hereby assign to the Practice all of my right, title and interest in any cause of actions and/or payment due to me (or due to my dependents or my estate) under any employee benefit plan, insurance plan, union trust fund, or similar plan ("Plan"), under which I am a participant or beneficiary for services, drugs or supplies provided by the Practice to me. I also hereby designate Cobb Nephrology/Hypertension Associates, P.C. as a beneficiary under any such Plan, and instruct that any payment be made solely to and sent directly to the Practice. If I receive any payment directly from any Plan for services, drugs or supplies provided to me by the Practice, including insurance checks, I recognize that such payment sent directly to me was inappropriate, and I agree to immediately endorse and forward such payment to the Practice. I agree that the Practice shall have an automatic lien against any such payment I receive from any Plan. If I fail any of my obligations under this provision, I understand that the Practice may pursue collections and legal action against me. In this case, I shall be responsible for the costs of collection (including reasonable attorneys' fees) that are incurred by the Practice.
6. **Collection of Benefits.** I agree to assist and cooperate fully with Cobb Nephrology/Hypertension Associates, P.C. to obtain payment from any Plan for services, drugs or supplies provided to me by the Practice.
7. **Patient Deductible, Coinsurance and Co-payments**. For Medicare and certain other insurance companies where the Practice accepts the charge determination as full payment, I am responsible only for my annual deductible, coinsurance and my co-payments, if any.
8. **Change of Information**. I agree to promptly notify Cobb Nephrology/Hypertension Associates, P.C. of any changes to my employment, insurance coverage, financial status, or my personal information (e.g., address, last name, etc.), within two (2) business days of any such change.
9. **Successors, Heirs and Estate**. I desire that the obligations and representations contained in this documents be binding on my heirs, legal representatives, successors and my estates. I agree not to assign my benefits under any Plan to any other person or firm for services, drugs or supplies provided to me by the Practice. This Form shall continue in full force and effect while I am receiving treatment from the Practice and thereafter, until the Practice is paid in full for services, drugs and supplies provided to me by the Practice. I understand that if I do not fulfill the above terms and conditions, the Practice may pursue payment from me directly, as appropriate, and/or ask me to immediately transfer to another medical practice. If any of this from is deemed unenforceable, the remaining provision shall remain in full force and effect.

This Form has been explained to me in person by the Cobb Nephrology/Hypertension Associates, P.C. staff member identified below.

FAILURE TO OBTAIN REQUIRED REFERRAL/ ACKNOWLEDGMENT OF PAYMENT RESPONSIBILITY

I understand that as a result of my NOT having a referral required by my insurance company at the time of my appointment, I will be responsible for payment for services rendered at the time of this appointment.

MISSED APPOINTMENTS

I understand that, **in the event that I fail to give 24 hour notice to this office, I will be charged $25.00 for a missed appointment**. I also understand that this charge will be billed to me and is not paid or reimbursed by my insurance company. I further understand that repeated failures to appear for my scheduled appointments without 24 hours prior notice to this office may result in termination of the physician- patient relationship.

_____ _____ Date: _____

Patient Signature Print Patient Name

_____ _____ Date: _____

Staff Member Signature Print Staff Member Name

COBB NEPHROLOGY/HYPERTENSION ASSOCIATES, P.C.

CONSENT FOR USE AND DISCLOSURE OF MEDICAL INFORMATION

Purpose: This form is to obtain an individual's consent to our use and disclosure of the individual's protected health information to carry out treatment activities, payment activities, health care operations and other functions.
To the Patient or the Patient's Personal Representative: Please read the following statements carefully.
Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information as follows:

- For our treatment activities, payment activities and health care operations as permitted by the HIPAA Privacy Rule;
- For the treatment activities, payment activities and health care operations of another health care provider or covered entity as permitted by the HIPAA Privacy Rule;
- For the health care operations of the Organized Health Care Arrangement in which we participate;
- To your family members, friends and others involved in your health care and the payment for your health care services including picking up medical equipment, supplies or pharmaceuticals on your behalf;
- To disaster relief organizations, as may be necessary to assist them in identifying or locating your family members and other responsible for your health care;
- In furtherance of the public interest and public benefit activities permitted by the HIPAA Privacy Rule, 45 C.F.R. §164.512, and our Health Information Policies and Procedures.

Effect of Declining Consent: **This consent is a condition of your treatment by us. If you decide not to sign this consent, we may decline to treat you.**
Notice of Privacy Practices: A copy of our Notice of Privacy Practices accompanies this consent. We encourage your to read it carefully and completely before signing this consent.
Right to Revoke: You will have the right to revoke this consent at any time by completing the revocation. Revocation of this consent will not affect any action we took in reliance on this consent before we received your written notice of revocation. **We may decline to treat you or continue treating you if you revoke this consent.**
I have had full opportunity to read and consider the contents of this consent form and your Notice of Privacy Practices. I understand that, by signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carryout treatment activities, payment activities, health care operations and other functions and activities described herein.
I attest that the above information is correct:

AUTHORIZATION FOR RELEASE OF INFORMATION TO COBB NEPHROLOGY/HYPERTENSION ASSOCIATES, P.C.

I, _____ DOB: _____ authorize _____ to release copies of my medical record including the following:

☐ History and Physical	☐ Operation Reports	☐ Laboratory Reports
☐ Consultation Reports	☐ Other; specify:	☐ Pathology Reports
☐ Discharge Summary	☐ Radiology Reports	☐ Complete Medical Record

I understand that these records may contain psychiatric, drug, alcohol abuse, and / or infectious disease information. I want this information released to:

Cobb Nephrology/Hypertension Associates, P.C.
3875 Austell Rd Ste 101
Austell GA, 30106
Phone: 678-460-2700 FAX: 877-784-4013

for the purpose of _____.
I hereby release _____, **from all legal liability that may arise from release of information in my medical record as authorized by this request.**

AUTHORIZATION FOR RELEASE OF INFORMATIONBY COBB NEPHROLOGY/HYPERTENSION ASSOCIATES, P.C.

I, _____ authorize Cobb Nephrology/Hypertension Associates, P.C. to release copies of my medical record including the following:

☐ History and Physical	☐ Radiology Reports
☐ Consultation Reports	☐ Laboratory Reports
☐ Discharge Summary	☐ Pathology Reports
☐ Operation Reports	☐ Complete Medical Record
☐ Other; specify:	

I understand that these records may contain psychiatric, drug, alcohol abuse, and / or infectious disease information. I want this information released to:

_____
_____
_____

Phone: (___) ___-____ **Facsimile: (___) ___ - ____**

for the purpose of _____.
I hereby release **Cobb Nephrology/Hypertension Associates, P.C.**, from all legal liability that may arise from release of information in my medical record as authorized by this request.

_____ _____ _____ _____
Patient Signature Date WITNESS DATE

_____ _____
Representative Signature/Relationship Date

COBB NEPHROLOGY/HYPERTENSION ASSOCIATES, P.C.

Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I, _____ Date of Birth_____ understand that as part of my health care, Cobb Nephrology/Hypertension Associates, PC, originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment;
- A means of communication among the many health professionals who contribute to my care;
- A source of information for applying my diagnosis and surgical information to my bill;
- A means by which a third-party can verify that services billed were actually provided; and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent;
- The right to object to the use of my health information for directory purposes; and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

I understand that Cobb Nephrology/Hypertension Associates, P.C. is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Cobb Nephrology/Hypertension Associates, P.C. reserves the right to change their notice and practices and prior to the implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Cobb Nephrology/Hypertension Associates, P.C. change their notice, they will send a copy of any revised notice to the address I've provided (whether U. S. mail or, if I agree in writing, by email).

I wish to have the following restrictions to the use or disclosure of my health information.

( ) **No Restrictions**

( ) **Other**.

State all restrictions: _____

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosure via facsimile.

PATIENT'S RIGHTS

As a Cobb Nephrology/Hypertension Associates, P.C. patient you are entitled to the following:

1. To be fully informed of your rights, responsibilities and all rules governing conduct related to patient care, services and financial policies/responsibilities.
2. To be accepted for admission without regard to national origin, race, age, sex, religion, disability or other factors unrelated to the provision of appropriate medical care.
3. To be treated with respect, dignity, and recognition of your individuality and personal needs, including the need for privacy and confidentiality in all aspects of treatment.
4. To receive all information in a way that you can understand.
5. To be fully informed of all services available in the Practice.
6. To be fully informed of your medical condition by your physician.
7. To receive a full explanation by your physician of the nature of and necessity for recommended treatment/appointment(s), including the risks and side effects and other treatment/appointment options before giving consent to treatment/appointment.
8. To refuse treatment/appointment to the extent permitted by law and to be fully informed of the medical consequences of refusing treatment/appointment.
9. To be fully informed or reasons for discharge or transfer from the Practice and to be given advance notice of thirty (30) days unless the reason involves issues of immediate safety to other patients or the Practice's staff members.
10. To review your medical record with supervision by the Practice Administrator or designee and at a time mutually agreed upon by you and the Practice Administrator or designee in advance.
11. To request a copy of your medical records.
12. To know your medical records and the information contained will be considered confidential.
13. To freely express grievances verbally or in writing to the Practice staff members, Practice Administrator and/or your treating physician without fear of reprisal, discrimination or retaliation.

I understand my patient rights as a patient of the Practice.

PATIENT'S RESPONSIBILITIES AND THE PRACTICE RULES

As a Cobb Nephrology/Hypertension Associates, P.C. patient you have the following responsibilities to yourself and to the Practice. There may be consequences if you fail to fulfill these responsibilities, which can include but are not limited to, physical side effects, and temporary or permanent dismissal from the Practice.

Cobb Nephrology/Hypertension Associates, P.C. takes all threats of workplace violence very seriously and supports Workplace violence: Zero Tolerance Policy:

- Acts or threats of violence by anyone on Cobb Nephrology/Hypertension Associates, P.C. premises will not be tolerated.
- Verbal, physical or visual intimidation or harassment by anyone will not be tolerated
- Violations of this policy may lead to temporary or permanent dismissal from the Practice.
- Everyone is responsible for immediately reporting acts or threats of violence, intimidation or harassment. These reports should be given to the Practice Administrator or other Cobb Nephrology/Hypertension Associates, P.C. staff member as appropriate.
- Specific examples of conduct that may be considered threats or acts of violence include, but are not limited to, the following:
  - Hitting or shoving an individual
  - Physically or verbally threatening an individual or his/her family, friends, associates or property with harm
  - The intentional destruction or threat of destruction of property
  - Harassing or threatening phone calls
  - Harassing, surveillance or stalking
  - The suggestion or intimation that violence is appropriate

COBB NEPHROLOGY/HYPERTENSION ASSOCIATES, P.C.

In addition, you are responsible for adhering to the rules of the Practice. Failure to adhere to these rules may result in the consequences listed above.

1. You have the responsibility to comply with the Cobb Nephrology/Hypertension Associates, P.C. Financial Policies and are required to sign the Assignment of Benefits forms, which includes consent for release of medical information for insurers.
2. You have the responsibility for providing Cobb Nephrology/Hypertension Associates, P.C. with true, correct, accurate, and valid identification, demographic and insurance coverage information upon registration with Cobb Nephrology/Hypertension Associates, P.C. and throughout the course of your receiving treatment from Cobb Nephrology/Hypertension Associates, P.C.
3. You are to come for your appointment as scheduled and to arrive on time.
4. You are responsible for treating other patients, visitors and the Practice staff members with consideration and respect.
5. You are responsible for treating other patient's information as confidential.
6. You are considered an important part of your healthcare team and you are encouraged to participate in the planning process.
7. You are responsible for making child care arrangements so that children are not bought to the office of the Practice without supervision.
8. You have a responsibility to tell the staff member or your treating physician if you have experienced any health problems between treatments, have seen a physician in another practice or have been given new medications and/or had old medications changed.
9. You are responsible for following the directions from your treating physician which are designed to prevent health problems.

NOTICE ACKNOWLDGEMENT

Purpose: This form is used to document a patient's acknowledgement of receipt of our Privacy Practices Notices or our good faith, but unsuccessful effort to obtain that acknowledgement. We are not obligated to attempt to obtain this acknowledgement in an emergency treatment situation

TO THE PATIENT: Please complete the following acknowledgement.

☐ **I acknowledge that I received the Privacy Practices Notice of this health care provider. (Please sign in space where indicated below.)**

TO THE PRACTICE STAFF MEMBER: Please complete the following if the patient is unable to sign and sign in the space below.

If the individual refused or was unable to sign an acknowledgement that the individual received our Privacy Practices Notice, please check appropriate box below. Describe your good faith effort to obtain the individual's signed acknowledgement and the reason you were unsuccessful.

☐ **Individual refuses or was unable to sign an acknowledgement that the individual received our Privacy Practices Notice. Describe your good faith effort to obtain the individual's signed acknowledgement and the reason you were unsuccessful.**

☐ **Individual received our Privacy Practices Notice in connection to an emergency treatment situation. We are therefore not required to obtain an a acknowledgement.**

(Please check
This form has been signed by: one)

☐ **Patient**

☐ **Patient's Personal Representative**

☐ **Practice Staff Member**

I attest that the above information is correct: _____ Signature

PERMISSION TO DISCUSS HEALTH INFORMATION WITH OTHER INDIVIDUALS

☐ I currently do not wish to give Cobb Nephrology/Hypertension Associates, P.C., permission to discuss my health information with any friends or relatives. I understand that if this request changes I am required to submit a new permission form.

☐ I hereby grant Cobb Nephrology/Hypertension Associates, P.C., Inc., permission to discuss my health information with the persons listed below as it relates to their involvement in the coordination of my care and payment for health care services I receive.

1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	

This form supersedes any and all previously completed forms. All previous forms are hereby revoked.

☐ I am the **Patient**

☐ I am the **Personal Representative of the Patient**: I represent that I am the legal parent/Guardian/Personal Representative of the Patient named above and I am not prohibited by Court Order from releasing access to the requested information.

_____ _____
Signature Date

_____
Printed Name

COBB NEPHROLOGY/HYPERTENSION ASSOCIATES, P.C.

PATIENT INFORMATION

Did a Physician send you? ( ) Yes ( ) No Why?
Physician name:
Physician address:
Who is your primary-care-doctor?(Name, address, phone)
Race: Asian Black/African American American Indian Nat Hawaiian Other Unknown White Ethnicity: Hispanic/Latino Not Hispanic/Latino Unknown
Name of person completing this form: Relationship to Patient:

Patient Name:	DOB:
Patient Address:	Work Phone #
Home Phone #:	Cell Phone #:
Employer's Name:	Patient E-mail:
Employer's Address:	
Employer's Phone #:	
Employed □ Unemployed □	Disabled □ Retired □
Emergency Contact:	Relationship:
Emergency Contact Address:	Emergency Contact Phone # Cell #

Pharmacy Information

Cobb Nephrology is utilizing e-scribing, which will e-mail your prescriptions direct to the pharmacy. The following information is required to enable us to complete this process.

Pharmacy Name:	City & State:
Phone #:	Fax # :
Mail In Pharmacy:	City & State:
Phone #:	Fax #:

COBB NEPHROLOGY/HYPERTENSION ASSOCIATES, P.C.

INSURANCE INFORMATION:

Patient Name:	DOB:

Primary Insurance Company Name:	
Address	
Phone #:	Policy ID# Group #
Policy Holder's Name	Relationship:
Effective Date:	Benefits: HMO PPO POS

Secondary Insurance Company Name:	
Address:	
Phone #:	Policy ID#: Group #:
Policy Holder's Name:	Relationship:
Effective Date:	Benefits: HMO ☐ PPO ☐ POS ☐
Additional Insurance:	

REMINDER Patients are responsible for obtaining referrals if required by insurance.

COBB NEPHROLOGY/HYPERTENSION ASSOCIATES, P.C.

PAST MEDICAL HISTORY:

	YES	NO	When?	Dr. Treating		Yes	NO	When ?	Dr. Treating
Cataract					Stroke				
Cancer					Hypertension				
Heart Disease					Kidney Stones				
Peripheral Vascular Disease					Kidney/ Pancreas Transplant				
Lung Disease					Polycystic Kidney Disease				
Stomach Disease					Urinary Tract infection				
Bowel Disease					Anemia				
Diabetes					Blood Transfusions				
High Cholesterol					Arthritis				
Thyroid Disease					Hepatitis				
Tranplant									

If Yes: Give Details What Kind, When, Where

_____

Other medical problems not listed above:

_____

PAST SURGICAL HISTORY: List any and all surgeries. List name of doctor who performed the surgery, when and where?

_____

_____

MEDICATIONS:
Identify current prescription and non-prescription (over the counter) medications. **List all medications that you are presently taking**, including, but not limited to, vitamins, nutritional supplements, oral contraceptives, pain relievers, and cold medicines.

If you are not presently taking any prescriptive or over the counter medications initial here:
None: _____

Name of Medication	Dose (mg)	Frequency (times/day)

Patient Name_____ **Date of Birth**_____

COBB NEPHROLOGY/HYPERTENSION ASSOCIATES, P.C.

ALLERGIES:
Have you had hives, skin rash, breathing problems, or other allergic reactions to medicine?
( ) Yes ( ) No
If yes, please specify below:

Name of Medication	Describe Allergic Reaction

FAMILY HISTORY:

	Mother	Father	Brother	Sister	Grandparents Maternal	Grandparents Paternal	Aunts	Uncles
Cancer								
Heart Attack								
Diabetes								
High Cholesterol								
Stroke								
Hypertension								
Kidney Stones								
Kidney Disease								
Other								

SOCIAL HISTORY:
Martial Status: Single ( ) Married ( ) Divorced ( ) Widowed ( )
Exercise: Yes or No: Regularly _____ Moderately _____ Occasionally ____ Sedentary_____

Please Answer with "X"	Yes	No	How Much	Age Started	Age Stopped
Tobacco					
Alcohol					
Illicit Drugs					

Name:_____DOB:_____