# KANSAS NEPHROLOGY PHYSICIANS, P.A.

### Disclosure of Ownership

As part of your care: the physicians of Kansas Nephrology Physicians, PA may suggest a referral for various services.

Kansas Nephrology Physicians, PA owns Kansas Vascular Access Center, LLC. Kansas Nephrology Physicians, PA also has partial ownership in FMC Midwest Dialysis Centers, LLC (Fresenius).

You are free to obtain your services elsewhere if you prefer. Upon request, we will be happy to provide you with names of alternate recommended facilities.

### Acknowledgement of Notice of Privacy Practices

I have been provided with Kansas Nephrology Physicians, PA's "Notice of Privacy Practices for Protected Health Information (Privacy Notice)" that describes how my medical information is used and disclosed and how I can get access to this information. I understand that Kansas Nephrology Physicians, PA reserves the right to change its notice. I understand that I can obtain a copy at any time on the patient portal, by stopping by the office or by contacting the practice's Privacy Officer at (316)263-7285.

### Assignment of Benefits

I authorize the holder of medical or other information about me to release to the Social Security Administration, its intermediaries, any other government agency, or insurance carrier responsible for payment, any information needed for the processing of this or related claims. I permit a copy of this authorization to be used in place of the original. And I request payment of medical insurance benefits directly to the provider who accepts this assignment. I understand I am financially responsible for any charges not covered by this assignment.

### Medication Records

I authorize Kansas Nephrology Physicians, PA to use SureScripts, Inc, a prescription system that allows prescriptions and related information to be exchanged between my provider and the pharmacy. The information sent between these systems may include details of any and all prescription drugs I am currently taking and/or have taken in the past. This information will be utilized by Kansas Nephrology Physicians, PA.

### Photo Consent

* Accept - I consent to the taking of my photograph for patient identification.
* Decline - I do not consent to the taking of my photograph for patient identification.

#### Patient Signature: Dated:

Patient Printed Name: DOB:

or

Personal Representative of Patient:

Description of Representative's Authority to Act for Patient:

Dated:

#### Patient's Nephrologist:

# \*\*TO BE COMPLETED BY PATIENTS WITH MEDICARE ONLY\*\*

## ONE TIME AUTHORIZATION

*Approved Form No: 0MB No. 0938-0222*

NAME OF BENEFICIARY HEALTH INSURANCE CLAIM NUMBER (HIC)

#### \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I request that payment of authorized Medicare Benefits be made either to me or on my behalf to Kansas Nephrology Physicians, P.A. for any services furnished to me by Kansas Nephrology Physicians, P.A. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services (CMS) and its agents any information needed to determine these benefits or the benefits payable for related services.

PATIENT'S SIGNATURE DATE SIGNED

## MEDICARE SECONDARY PAYER QUESTIONNAIRE (TO BE COMPLETED FOR ALL MEDICARE PATIENTS)

Patient's Name:  **\_\_ \_\_**

Patient's SS#: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

PATIENT'S SIGNATURE DATE SIGNED

1. Is the patient a Veteran?
   1. Did the VA refer you here for treatment?
   2. Does the patient have a VA "fee basis ID Card?"
2. Do you have a Federal Black Lung Card?
3. Is this medical condition due to an accident of any kind?

YES NO

If yes was it: Work Related

Auto

Injured in own home

Other

1. Is the patient covered by an employer's health insurance plan through their own employment or that of a family member? (not retiree coverage)

#### Patient's Nephrologist:

# KANSAS NEPHROLOGY PHYSICIANS, P.A.

### Permission to Disclose Information to Those Involved in My Care

#### Emergency Contact: Mobile number:

**Emergency Contact Relationship: Home number:**

**We utilize a patient communicator system to contact you regarding your medical care. The system will send out messages by phone, text and email. You may opt out of any of these forms of communication at any time. However, if you opt out of all forms of communication, you will not receive a reminder of upcoming appointments.**

Mobile number:

Home number:

(if applicable)

Email address:

(Please Print)

#### Preferred Pharmacy:

**Preferred Lab Facility:**

* Kansas Nephrology Physicians (Wichita office)
* Outside Lab Facility:

### Patient Signature:

**Patient's Nephrologist:**

**Dated:**

### PAST MEDICAL HISTORY - COMMON DISEASES

#### Do you have a personal history of any of the following?

|  |  |  |
| --- | --- | --- |
| Kidney Disease | * Chronic Kidney Disease Stage: 1 2 3 4 5 * Transplant   + Cadaveric   + Living - Related   + Living - Unrelated | * Dialysis   + Hemodialysis   + Peritoneal Dialysis * Polycystic Kidney Disease * Acute Kidney Injury * Glomerulonephritis |
| Diabetes | * Type 1 * Type 2 | * Type Unknown |
| High Blood Pressure | * High Blood Pressure |  |
| Ischemic Heart Disease | * Heart Attack * Angina * Angioplasty | * Coronary Stent * CABG (Coronary Artery Bypass Graft) |
| Cancer | * Lung * Breast * Prostate * Colon * Melanoma * Bladder | * Lymphoma * Kidney * Thyroid * Leukemia * Endometrial * Pancreatic |
| Stroke | * Stroke |  |
| Gout | * Gout |  |

**PAST MEDICAL HISTORY - ADDITIONAL CONDITIONS**

**Do you have a personal history of any of the following?**

|  |  |  |
| --- | --- | --- |
| EENT | * Blindness * Cataracts | * Hearing Problems * Glaucoma |
| Cardiovascular | * Atrial Fibrillation * Pacemaker * AICD (Cardiac Defibrillator) | * Valvular Heart Disease * Congestive Heart Failure * Mitral Valve Prolapse |
| Respiratory | * COPD * Chronic Bronchitis * Asthma * Emphysema | * Pneumonia * Tuberculosis * Sleep Apnea |
| Gastrointestinal | * GERD (Gastric Reflux) * Gastric Duodenal * Gall Bladder Disease * Hepatitis | * Inflammatory Bowel Disease * Irritable Bowel Syndrome * Gluten Intolerance * Lactose Intolerance |
| Genitourinary | * Enlarged Prostate * Kidney Stones | * Frequent UTIs (Urinary Tract Infections) |
| OB History | * Preeclampsia * Pregnancy Induced Hypertension | * Gestational Diabetes * History of Complicated Pregnancy |
| Musculoskeletal | * Osteoarthritis | * Osteoporosis |
| Neurological | * Multiple Sclerosis * Seizures | * Parkinson's * Dementia |

|  |  |  |
| --- | --- | --- |
| Psychiatric | * Depression | * Anxiety Disorder |
| Endocrine | * Hypothyroidism * Hyperthyroidism | * Adrenal Insufficiency |
| Hematology | * Anemia * Sickle Cell Disease * Sickle Cell Trait | * Blood Transfusion * Thalassemia |
| Immuno/ Allergy | * HIV * AIDS | * Rheumatoid Arthritis * Lupus |

**Patients Nephrologist:**

### PAST MEDICAL HISTORY - SURGERY HISTORY

Have any of the following surgeries been performed on you?

|  |  |  |
| --- | --- | --- |
| * Appendectomy * CABG * Carotid Endarterectomy * Cataract Surgery * D & C * Gall Bladder Removal * Gastric Bypass * Hemorrhoidectomy * Hernia Repair | * Hip Replacement   + Left ☐ Bilateral   + Right * Knee Replacement   + Left ☐ Bilateral   + Right * Hysterectomy * Prostatectomy * Nephrectomy | * Renal Transplant * Thyroidectomy * Tonsillectomy * Valve Replacement * AV Fistula * AV Graft * PD Catheter * Other |

Other Health Problems Not Listed Above

### FAMILY HISTORY-STATUS

#### Do the following family members have any of the following medical conditions?

|  |  |  |
| --- | --- | --- |
| Kidney Disease | * Father * Mother | * Sibling * Child |
| Diabetes | * Father * Mother | * Sibling * Child |
| High Blood Pressure | * Father * Mother | * Sibling * Child |
| Ischemic Heart Disease | * Father * Mother | * Sibling * Child |
| Cancer | * Father * Mother | * Sibling * Child |
| Stroke | * Father * Mother | * Sibling * Child |
| Gout | * Father * Mother | * Sibling * Child |
| Polycystic Kidney Disorder | * Father * Mother | * Sibling * Child |
| Dementia | * Father * Mother | * Sibling * Child |

**FAMILY HISTORY-STATUS**

|  |  |  |
| --- | --- | --- |
| Father | * Living * Unknown | * Deceased   + Age at Death:   + Cause of Death: |
| Mother | * Living * Unknown | * Deceased   + Age at Death:   + Cause of Death: |

**Other Family History Not Listed Above:**

**SOCIAL HISTORY - GENERAL**

|  |  |  |
| --- | --- | --- |
| Current Marital Status | * Married * Separated * Single | * Widowed * Divorced |
| Living Arrangement | * Alone * Family Member * Spouse | * In Home Caregiver * Significant Other * Assisted Living Facility |
| Occupation | * Employed   + Full-time   + Part-time | * Retired * Unemployed * Student |
|  | List your Current or Former Occupation: | |
| Other | * Hearing Loss * Limited Mobility | * Poor Vision or Blindness * Transportation Challenges |

**Patients Nephrologist:**

**SOCIAL HISTORY-HABITS**

|  |  |  |
| --- | --- | --- |
| Tobacco Use | * Current or ☐ Former User   + Cigarettes   + Chewing Tobacco   + Pipes   + Snuff   + Cigars | * Never Used * Unknown |
|  | **If a former user, what year did you quit?** | |

#### Complete this section only if you are a current or former cigarette user

|  |  |  |  |
| --- | --- | --- | --- |
| How often do you currently smoke or how often did you smoke before you quit?   * Every Day ☐ Some Days ☐ Unknown   How Many Packs per day do you currently smoke or how many packs per day did you smoke before you quit?  How many total years have you used cigarettes? | | | |
| Alcohol Use | * Current or ☐ Former User   + Occasional   + 1-2 drinks per Day   + 3 or more drinks per Day | | * Never Used |
|  | **If a former use, what year did you quit?** | | |
| Recreational Drug Use | * Current of Former User   + Marijuana   + Amphetamines   + LSD   + Heroin   + Ecstasy * Never used | * Opium * Cocaine * Barbiturates * Other | |
|  | If a former use, what year did you quit? | | |

Other Social History Not Listed Above:

#### REVIEW OF SYSTEMS

|  |  |  |
| --- | --- | --- |
| Constitutional | * Fever * Weight Gain * Weight Loss | * Fatigue * Chills * Weakness |
| HEENT | * Vision Impaired * Eye Pain * Redness * Color Blindness * Double Vision * Hearing Loss * Ear Pain | * Sinus Problems * Sore Throat * Nose Bleeds * Headache * Hoarseness * Tinnitus * Vertigo |
| Respiratory | * Shortness of Breath   + At Rest   + With Activity * Pain with Breathing | * Cough * Wheezing * Blood in Sputum * Night Sweats |
| Cardiovascular | * Chest Pain or discomfort * Pounding heart * Pain in Legs When Walking | * Swelling |

**Patients Nephrologist:**

|  |  |  |
| --- | --- | --- |
| Gastrointestinal | * Abdominal Pain * Nausea * Diarrhea * Heartburn * Vomiting | * Constipation * Anorexia * Trouble Swallowing * Indigestion |
| Genitourinary | * Urinary Urgency * Urinary Burning or Pain * Blood in Urine * Urinary Frequency | * Urinary Hesitancy * Foamy Urine * Incontinence * Nocturia |
| Musculoskeletal | * Back Pain * Neck Pain * Joint Pain * Muscle Pain * Arm Weakness   + Left   + Right   + Both | * Leg Weakness   + Left   + Right   + Both |
| Skin | * Rash * Itching * Scaling | * Dryness * Color change |
| Neurological | * Numbness * Tremors * Seizures | * Tingling * Fainting |
| Psychiatric | * Depression * Insomnia | * Anxiety |
| Endocrine | * Heat Intolerance * Cold Intolerance | * Excessive Thirst * Excessive Urination |
| Hematology | * Bleeding Gums | * Easy Bruising |
| Immuno/ Allergy | * Seasonal Allergies | * Hives |

Other Review of Systems Not Listed Above:

#### Patient's Nephrologist:

### Please List the Medications you are Currently Taking Below:

#### (Printed list of medications is also accepted)

|  |  |  |
| --- | --- | --- |
| **Medication**  (Example: *Hydralazine*) | **Dosage**  (Example: *25mg*) | **Frequency**  (Example: *Take 1 Tablet 3 Times a Day*) |
| **1.** |  |  |
| **2.** |  |  |
| **3.** |  |  |
| **4.** |  |  |
| **5.** |  |  |
| **6.** |  |  |
| **7.** |  |  |
| **8.** |  |  |
| **9.** |  |  |
| **10.** |  |  |
| **11.** |  |  |
| **12.** |  |  |
| **13.** |  |  |
| **14.** |  |  |
| **15.** |  |  |
| **16.** |  |  |
| **17.** |  |  |
| **18.** |  |  |
| **19.** |  |  |
| **20.** |  |  |
| **21.** |  |  |
| **22.** |  |  |
| **23.** |  |  |
| **24.** |  |  |
| **25.** |  |  |

**\*\*Please bring pill bottles with you to your appointment\*\***

**Patients Nephrologist:**

**Allergies**

#### Please List any Allergies to Medications that you have and what Symptoms you had.

|  |  |
| --- | --- |
| **Medication** | **Symptoms** |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Have you ever had a pneumonia vaccination? | Yes | No | If yes, | when? |
| Have you ever had a flu shot? | Yes | No | If yes, | when? |
| Have you ever had a Hepatitis B Vaccination? | Yes | No | If yes, | when? |
| When was your last: |  |  |  |  |

Tetanus Shot Mammogram Pap Smear (Female) PSA (Male)

#### Please list other doctors whom you see:

|  |  |
| --- | --- |
| **Family Practitioner (PCP)** |  |
| **Cardiologist** |  |
| **Gastroenterologist** |  |
| **Orthopedist** |  |
| **Urologist** |  |
| **Dermatologist** |  |
| **Neurologist** |  |
| **Pulmonologist** |  |
| **Endocrinologist** |  |
| **Gynecologist** |  |
| **Ophthalmologist** |  |
| **Other** |  |
| **Other** |  |

**Patient's Nephrologist:**

**KANSAS NEPHROLOGY PHYSICIANS, P.A.**

Patient's Name:DOB:

#### Many insurance companies require us to document the following information. Please take a few minutes to answer the questions below. Thank you.

**Ethnicity:**

Hispanic or Latino

Not Hispanic or Latino

Unknown

Declined

#### Primary Race:

White African American Hispanic or Latino

American Indian or Alaska Native Samoan

Asian Japanese Vietnamese

Chinese Korean

Filipino Native Hawaiian or Other Pacific Islander

Guamanian or Chamorro

Other Declined

#### Primary Language:

English Spanish

Arabic Japanese

Chinese Korean

French Vietnamese

German Other

#### Patient's Nephrologist: