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

	YES	NO
1. Is the patient a Veteran?	_____	_____
a. Did the VA refer you here for treatment?	_____	_____
b. 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?	_____	_____

If yes was it: Work Related _____ Auto _____ Injured in own home _____ Other _____

4. 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: _____ **Dated:** _____

Patient's Nephrologist:

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: