

Patient Registration Form
(Please Print)

Appointment Date: _____

****Patient Information****

SEX: Male/Female

Last Name: _____ First Name: _____
MI: _____
Nick Name: _____ SSN: _____
Pt. Address: _____
Birth Date: _____
City/St/Zip: _____ Hm Phone: _____
Cell Phone: _____

Matial Status: Single Married Divorced Widowed Language: English Spanish Other
Ethnic Origin: Am Indian Asian Black White Hispanic Multi-Racial Other

Email: _____
Primary Care Physician: _____ Phone: _____
Referring Physician: _____ Phone: _____

****Patient Employment Info****

Patient Employer: _____ Employer Address: _____
Employer Date of
City/St/Zip: _____ Retirement: _____ Employer
Phone: _____

****Relative Emergency****

Name: _____ Contact Address: _____
Phone: _____ Relationship: _____

****Insurance Information****

Please present your Drivier's License and Insurance Cards to the receptionist. If you are unable to provide these, you may be considered a self paying patient.

Primary Insurance: _____ Secondary
Insurance: _____
Plan Name: _____ Plan Name: _____
Policy #: _____ Policy #: _____
Subscriber Name: _____ Subscriber Name: _____
Group Name/S: _____ Group Name/S: _____
Subscriber Birth Date: _____ Subscriber Birth Date: _____

****Special Permissions****

PLEASE INITIAL AND DATE APPLICABLE STATEMENTS BELOW:

I GIVE PERMISSION TO LEAVE VOICE MAIL OR ANSWERING MACHINE MESSAGES AT MY HOME. THE MESSAGE CAN INCLUDE THE NATURE OF THE CALL, BUT NOT SPECIFIC INFORMATION.

I GIVE PERMISSION TO CALL ME ON MY CELL PHONE.

I GIVE PERMISSION TO DISCUSS MY MEDICAL AND DENTAL CARE AND BILLING INFORMATION WITH

AND I HAVE RECEIVED A NOTICE OF PRIVACY PRACTICES.

I PREFER TO RECEIVE ST LUKE'S HEALTH SYSTEMS INFORMATIONAL MAILINGS

Circle One: Yes No

I HAVE REVIEWD THE ABOVE INFORMATION AND, TO THE BEST OF MY KNOWLEDGE, IT IS CORRECT AND COMPLETE.

(Signature of Patient or Guardian):



Admission/Registration

Agreement

USE THIS AREA FOR STAMP OR LABEL WITH PATIENT INFORMATION

- I. **CONSENT FOR TREATMENT:** I consent to such routine diagnostic and treatment procedures/examinations and laboratory procedures considered reasonably necessary for the care and treatment of my condition during my admission to an Emory Healthcare Hospital or my outpatient care at an Emory Healthcare facility. I understand that diagnostic and treatment procedures involving material risks will be explained to me and that I will have the opportunity to ask questions concerning the associated risks, alternatives and prognosis before allowing the procedures to be performed. I understand that Emory Healthcare's mission includes training physicians and other medical personnel and conducting medical research. I acknowledge that students may participate in my care. If I am asked to participate in a research study, I may refuse to participate and my refusal will not affect or compromise my access to medical services.
- II. **INDEPENDENT CONTRACTORS:** I understand that some of the health care professionals providing care, treatment and services at the Emory Healthcare Hospitals or facilities are independent contractors, and are not agents or employees of the Hospitals or Emory Healthcare. Independent contractors are responsible for their own actions and neither the Hospitals nor Emory Healthcare shall be liable for the acts or omissions of any such independent contractors.
- III. **ASSIGNMENT OF BENEFITS/FINANCIAL AGREEMENT AND APPOINTMENT OF REPRESENTATIVE:** If I am entitled to benefits under the Medicare program, the Medicaid program, or any insurance policy or other health benefit plan (covering me or anyone legally responsible for me), in consideration for admission to and for services provided to me by an Emory Healthcare facility, I assign, transfer and convey the benefits payable under such program, policy or plan for services rendered during my admission to the Emory Healthcare facilities that provide services to me. I authorize payment of benefits directly to such Emory Healthcare facilities, with such benefits to be applied to my bill. I understand and acknowledge that this assignment does not relieve me of financial responsibility for charges incurred by me or anyone on my behalf, and I hereby acknowledge responsibility for and agree to pay charges not paid under this assignment, including any coinsurance amounts and deductibles and any charges for services deemed to be non-covered, not precertified or not preauthorized by my insurance plan.
- If my health care benefits are provided under a self-funded plan under the Employee Retirement Income Security Act - (ERISA), in order to assist me in obtaining my benefits: I authorize and appoint Emory Healthcare to act as my representative, when Emory Healthcare consents in writing to so act, in appealing any adverse benefit determination and to receive notices on my behalf with respect to same. I agree that I will comply with procedures established by my benefit plan relating to this authorization, if any.
- IV. **PERSONAL VALUABLES:** I understand that Emory Healthcare Hospitals and Budd Terrace maintain a safe for patient money and valuables and that neither the Hospitals nor Budd Terrace nor any Emory Healthcare facility shall be legally responsible for the loss of or damage to any money, jewelry, glasses, hearing aids, dentures, documents or other articles of value, unless deposited with Emory Healthcare staff for safekeeping.
- V. **CONSENT FOR DISCLOSURE OF INFORMATION:** I understand the Emory Healthcare facilities are permitted to disclose protected health information about me for purposes of payment, my continued care or treatment, and healthcare operations. If my protected health information includes any records containing information related to the treatment of any infectious disease (including AIDS confidential information), drug or alcohol abuse and/or mental illness, I hereby consent to the disclosure of this information by the Emory Healthcare facilities only as reasonably necessary to accomplish the purposes described above, and I waive any privileges with regard to such disclosure. I understand this consent permits release of the identified information to any insurance company, healthcare plan or any other person or entity financially responsible for my treatment if necessary for purposes related to filing a claim for payment, or, if I am being evaluated for a transplant, for purposes of determining eligibility, and to my referring physician and any health care practitioner, nursing home, health care facility, ambulance service, home health agency, government or private agency which may provide medical, mental health, rehabilitation, social or related services to me during or upon my discharge or transfer from an Emory Healthcare facility.

I understand my consent to disclosure of information related to treatment of any infectious disease (including AIDS confidential information), drug or alcohol abuse, or mental illness is valid until all bills related to my treatment have been paid and utilization and/or quality assessment have been completed. I further understand I can withdraw my consent for disclosure of such information at any time except to the extent action has been taken in reliance upon such consent.

- VI. **AGREEMENT TO ALTERNATIVE DISPUTE RESOLUTION:** I agree that any claim or dispute arising out of or related to the provision of health care services to me by Emory University, Inc. d/b/a Emory University Hospital, Emory University Orthopaedics & Spine Hospital and Emory University Hospital Midtown; The Emory Clinic, Inc. (and the Ambulatory

Surgery Center); Emory Healthcare, Inc.; Emory Children's Center, Inc.; Wesley Woods Long Term Acute Care Hospital; Wesley Woods Center of Emory University, Inc., or their employees or agents ("Emory"), except as otherwise provided herein, shall be resolved by final and binding arbitration. I agree that this provision is governed by the terms of the Federal Arbitration Act. I understand and agree that this agreement includes and encompasses any claims arising out of or relating to health care services which shall be provided to me upon this admission as well as all health care services provided to me by Emory in the future, provided, however, that this agreement does not include and encompass any claim or dispute by either party arising out of or related to the billing or payment for health care services. I understand and agree that by agreeing to arbitrate, I am waiving my right to a jury trial (if otherwise available). I understand that this agreement is also binding on any individual or entity claiming by or through me or on my behalf. I understand that this agreement is voluntary and is not a precondition to receiving health care services. The arbitration of any claim or dispute hereunder shall be conducted in the State of Georgia in accordance with the Rules and Procedures of Henning Arbitration and Mediation Services, Inc., a copy of which is available to me upon request. I understand that I have the right to revoke this agreement no later than ten (10) days following signature and that, if I choose to revoke, I must request and execute a revocation form within this time period.

NOTE: If the individual signing this agreement is doing so on behalf of his or her minor child or any other person for whom he or she is legally responsible, the signature below affirms that he or she has the authority or obligation to contract with Emory for the provision of health care services to that minor child or other person, and that his or her execution of this agreement is in furtherance of that authority or obligation.

DATE: _____, _____; _____
PATIENT, PARENT, GUARDIAN OR
AUTHORIZED REPRESENTATIVE

VII. PHOTOGRAPHS, VIDEOTAPES, AND RECORDINGS: I understand that the physicians or staff at certain of the Emory Healthcare facilities may request to take photographs, videotapes or other recordings of me for purposes of ensuring proper patient identification or for medical documentation, care or treatment purposes, and I consent to being photographed, videotaped, or recorded for these purposes. I further acknowledge that such photographs, videotapes, recordings, and related information may be used for internal operations purposes of Emory Healthcare, including, but not limited to medical education, training programs, quality assessment and improvement activities, outcomes evaluation, case management, and related functions that do not include treatment. I understand that such photographs, videotapes and recordings will be maintained in a secure manner and will not be disclosed for external use, except upon written authorization from me or my authorized representative or as required or permitted by law.

VIII. HOSPITAL PATIENT DIRECTORY: If I am a hospital patient, I understand the following information will be included in the Hospital Directory - my Name, my Room Number/Location, my General Condition such as Fair, Stable or Critical, and my Religious Affiliation (if expressed). I understand that my location in the hospital and my general condition will be provided to persons who inquire about me by name, and that my religious affiliation along with the other directory information will be provided to members of the clergy who request information on patients based on their religious affiliation. Patients in an Emory Healthcare Mental Health Unit are not included in the Hospital Directory.

If you are a hospital patient and do not want your information included in the Hospital Directory, please check Opt-Out of Hospital Directory below and initial.

• I Opt Out of the Hospital Directory _____ (please initial)

IX. ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received the Emory Healthcare Notice of Privacy Practices. _____
(please initial)

X. ACKNOWLEDGEMENT OF PERMISSIBLE PURPOSE TO OBTAIN CONSUMER REPORT: I acknowledge that, by requesting health care services at an Emory Healthcare facility, I am initiating a business transaction for which Emory Healthcare has a legitimate business need to obtain a consumer report that contains credit and personal information about me. I understand that Emory Healthcare may obtain such reports from credit reporting agencies and credit bureaus for uses permitted under the Fair Credit Reporting Act.

The date of this Admission Agreement is (insert today's date) _____

Witness

Signature of Patient or Patient's Representative

Relationship of Representative to Patient



Midtown Atlanta
nephrology, p.c.

Midtown Atlanta Nephrology, P.C.

550 Peachtree Street North East, Suite 1650 Atlanta, Georgia 30308

Ph# 404-523-8810 Fax: 404-523-8840

First Name MI Last Name

Authorize and request to release MAM PC a complete Copy of the Medical Records of :
Name of Patient

Date of birth _____, Social Security Number

From _____ to _____

Reason for disclosure is: _____

I am aware that some of the health care information or other information contained in the requested medical records may be confidential or privileged and I hereby specifically waive any privileges or confidentiality existing under the federal or state law regarding such information including but not limited to protection afforded to:

1. AIDS confidential information
2. Medical Information concerning alcohol and drug abuse
3. Medical Information regarding Mental Illness
4. Medical Information regarding Mental Retardation
5. Communication with Psychiatrists
6. Communication made to licensed applied Psychologists
7. Medical information concerning alcohol and drug dependence

This authorization and consent is subject to revocation at any time, except to the extent that action has already been taken in reliance on it. If not previously revoked, this authorization will terminate 90 days from the date appearing below.

Date _____ Signature _____

Witness _____ Title _____

This information was released to: _____

On _____ by

Kidney Care Excellence with a Warm Personal Touch

Review of Systems

CHECK ALL THAT APPLY:

GEN

- Persistent fever
- Fatigue
- Weight loss
- Night sweats Eyes
- Double Vision
- Blurred Vision
- Eye pain
- Eye redness
- Cataracts
- Glaucoma
- Loss of Vision
- Eye surgery
- Laser Surgery
- Dry eyes

Ears/Nose/Throat

- Loss of hearing
- Vertigo
- Ringing in ears
- Hoarseness
- Excessively dry mouth
- Nasal ulcer
- Nosebleeds
- Earaches
- Pain w/swallowing
- Ulcers in the mouth

Heart

- Chest pain at rest
- Chest pain with activity
- Feeling faint
- Heart murmur
- Heart valve problems
- Congestive heart Failure
- Inability to finish task in the past

- Coughing
- History of rheumatic fever
- History of strep throat
- High blood pressure
- Problems walking due to Calf pain
- Leg or ankle swelling
- Varicose veins
- Mitral Valve prolapsed
- History of heart stress test
If so when _____
- History of heart Cath If so when _____

Lungs

- Coughing
- Shortness of breath at rest
- Coughing up blood
- Sharp chest pain When inhaling
- Wheezing
- Tobacco use
- History of asthma
- Hay fever
- Pneumonia
- Bronchitis
- Tuberculosis or exposed to anyone with TB
- Positive TB skin test
- History of having abnormal chest x-ray
- Sinus infections
- Sore throat

Stomach

- Nausea
- Vomiting
- Diarrhea
- Constipation
- Unexplained weight loss
- Loss of appetite
- Ulcers reflux
- Dark stools resembling tar
- Hemorrhoids
- Indigestion
- Jaundice
- Gallstones
- Metallic or taste of foods
- Abdominal surgeries

Muscles and Joints

- Muscle aches
- Joints aches
- Leg cramps
- Gout
- Arthritis Nerves D numbness or tingling of the hands or feet
- Problems sleeping
- Restless legs at night
- Anxiety
- Depressed mood
- Dizziness when standing
- Fainting spells
- Seizures
- Weakness

Skin

- Dry itchy skin
- New rashes
- Yellowing of the eyes
- Ulcers in the mouth
- Hair loss
- Skin infections
- Boils abscess
- Bruises
- Hives Blood system
- Bruising easily
- Bleeding gums
- History of clots in the legs or lungs
- Prolongs bleeding
- Swollen glands

Endocrine

- Excessive thirst
- Weight loss
- Cold or heat intolerance
- Cholesterol problems
- History of thyroid disease
- History of high or low calcium levels
- Osteoporosis
- History of high or low potassium

Psychiatry

- Depression
- Agitation
- Anxiety or panic attacks
- Memory problems
- Hallucinations

Discussions of positives:

MD SIGNATURE

DATE

Name:

Date of Birth:

Past Medical History

- Heart Attack
- Stroke
- Mini Stroke (TIA)
- High Blood pressure
- Diabetes
- High Cholesterol
- Kidney Stones
- Kidney Cysts

CHECK ALL THAT APPLY:

- Protein in the urine
- Blood in the urine
- Lupus
- Gout
- Cancer
- Sickle cell disease
- Multiple myeloma
- Thyroid disease

- Hepatitis
- Cirrhosis of the liver
- HIV disease
- Procedures requiring contrast dye
- History of sexually transmitted disease
- Anemia
- Frequent kidney infection

Please list all operations and date:

Family History:

Has any member of your family had the following medical problems?

- Kidney failure requiring dialysis
- Kidney stones
- Diabetes
- Severe arthritis involving many joints
- High blood pressure
- Hearing loss
- Cysts involving the kidney or liver
- Brain aneurysms
- Cholesterol problems
- Thyroid disease
- Clotting or bleeding problems
- Heart attack or stroke at a young age men < 55, women < 80
- Lupus
- Cancer
- Sickle cell disease

Family Health Status:

Mother: Living Deceased
 Age. _____
 Causes of death _____

Father: Living Deceased
 Age. _____
 Causes of death _____ SIS: _____

Number of siblings BROs: _____
 Number of deceased siblings BRO: _____
 Cause of deaths _____

Social History:

Marital Status: M S
 # of children _____
 Years of formal education _____

Habits:

- Alcohol _____
- Tobacco products? ___
- Caffeine consumption?_
- Street drugs
- Regular exercise _____

Health Maintenance:

Mammogram _____
 Prostate exam _____
 Stool check for blood_ _____
 Flex Sig/Colonoscopy_ _____

OB-GYN History:

How many pregnancies have you had?_ _____
 How many deliveries? _____
 Have you experienced menopause?_ _____
 Date of last period. _____

Did you have problems with blood pressure during your pregnancy? _____

Did you have problems with your kidneys during your pregnancy? _____

Sexual History:

Have you had an HIV test before____
 When? _____

High risk sexual behavior
History of sexually transmitted disease:

MD Signature____
 Date _____