HUNTSVILLE RENAL CLINIC, P.C.

810 Franklin Street, Suite A
Huntsville, AL 35801
(256) 533-7676

PATIENT INFORMATION

First Name: _____ MI: _____ Last Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Telephone: (_____)_____ Cell Phone: (_____)_____
Emergency Contact: _____ Emergency Phone: (_____)_____
May we leave messages on your telephone voicemail? ❑ Yes ❑ No
Birth Date: _____/____/_____ Sex: _____ Marital Status: _____ Social Security No.: _____

Race: _____ Ethnicity: _____ ❑ Non-Hispanic ❑ Hispanic ❑ Wishes to not report
Language: _____ Referring Physician: _____

Maiden/Previous Name: _____ Spouse's Name: _____
Patient's Employer: _____
Employer's Address: _____ Suite #: _____
City: _____ State: ____ Zip: _____ Employer Phone: (_____)_____
If patient is over 18 and a student, please check: ❑ Employed ❑ Part-time ❑ Full-time Student

BILLING/GUARANTOR INFORMATION

First Name: _____ MI: _____ Last Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Telephone: (_____)_____

INSURANCE INFORMATION

PRIMARY INSURANCE: _____
Group No: _____ Policy No: _____ Copay Amt: _____
Subscriber Name: _____ Relationship to Patient: _____
Subscriber Sex: _____ DOB: ____/____/_____ SSN: _____
Subscriber Employer: _____ Work Phone: _____
Employer Address: _____

SECONDARY INSURANCE: _____
Group No: _____ Policy No: _____ Copay Amt: _____
Subscriber Name: _____ Relationship to Patient: _____
Subscriber Sex: _____ DOB: ____/____/_____ SSN: _____
Subscriber Employer: _____ Work Phone: _____
Employer Address: _____

If scheduled appointments are cancelled without 24 hours notice there will be a $25 cancellation fee. _____(initial)
I understand that I am financially responsible for the charges not covered by insurance.

_____ _____
Signature Date

General Information

Name: _____ Date: _____

Name you prefer to be called: _____ Date of Birth: _____

Race: ☐ African-American ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Indian ☐ Pacific Islander ☐ Other: _____

Allergies Please list any medicines you are allergic to and the reaction you had (e.g. hives, nausea, etc.)

1. _____
2. _____
3. _____

Medications Please list the dose and frequency of **all** medications you take including over the counter medications (e.g., aspirin, antacids, vitamins, etc.) and herbal supplements (garlic, cranberry, etc.)

1. _____ 7. _____
2. _____ 8. _____
3. _____ 9. _____
4. _____ 10. _____
5. _____ 11. _____
6. _____ 12. _____

Immunizations

Year of last flu vaccine _____

Year of last pneumonia vaccine _____

Year of Hepatitis B Vaccine _____

Dialysis History Yes | No

Start/End	Center	Type
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medical Illnesses

Acute Kidney Injury	No	Yes	GERD	No	Yes
Anemia	No	Yes	Gout	No	Yes
Atrial fibrillation	No	Yes	Hepatitis	No	Yes
Cancer	No	Yes	HIV/AIDS	No	Yes
CHF	No	Yes	Hyperkalemia	No	Yes
Chronic kidney disease	No	Yes	Hyperlipidemia	No	Yes
Clotting disorder	No	Yes	Hyperparathyroidism	No	Yes
COPD	No	Yes	Hypertension	No	Yes
Coronary artery disease	No	Yes	Hyponatremia	No	Yes
Diabetes mellitus	No	Yes	Hypothyroidism	No	Yes
Diabetic nephropathy	No	Yes	Kidney stones	No	Yes
Enlarged Prostate	No	Yes	Lupus	No	Yes
ESRD	No	Yes			

Surgical History

Bladder surgery	No	Yes	Kidney biopsy	No	Yes
Thyroid surgery	No	Yes	CABG	No	Yes
Kidney removal	No	Yes	Cardiac stent	No	Yes
Kidney stone surgery	No	Yes	Dialysis access surgery	No	Yes
Parathyroid surgery	No	Yes	Other:_____		
Transplant	No	Yes	Other:_____		

Family History:

Anemia:	☐ Father	☐ Mother	☐ Sibling	☐ Child	☐ Other
Autoimmune disease:	☐ Father	☐ Mother	☐ Sibling	☐ Child	☐ Other
Cancer:	☐ Father	☐ Mother	☐ Sibling	☐ Child	☐ Other
Diabetes:	☐ Father	☐ Mother	☐ Sibling	☐ Child	☐ Other
Hypertension:	☐ Father	☐ Mother	☐ Sibling	☐ Child	☐ Other
Kidney Disease:	☐ Father	☐ Mother	☐ Sibling	☐ Child	☐ Other
Heart Attack:	☐ Father	☐ Mother	☐ Sibling	☐ Child	☐ Other

Status:

Father	☐ Living	☐ Deceased	☐ Unknown
Mother	☐ Living	☐ Deceased	☐ Unknown

Social History

Tobacco use: ☐ Current user ☐ Former user ☐ Never used ☐ Unknown

Type: ☐ Cigarettes ☐ Pipes ☐ Cigars ☐ Chewing Tobacco ☐ Snuff

Packs/day: _____ Quit Date:_____

Years: _____ Counseling Given: Yes | No

Alcohol Use: Yes | No | Defer

Drinks/Week _____ wine _____ beer _____ liquor _____ standard drinks

Recreational Drug Use: Yes | No | Defer

Types of drugs used: _____

Use/week: _____

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GENERAL COMMUNICATION PREFERENCES

We would like to know how to best communicate with you. Please mark the boxes below giving us permission to call, email, and/or text you.

Home Phone Number: _____

Mobile Number: _____

Email Address: _____

	Home Phone	Mobile Phone	Email	Text Message	All
Appointments:	☐	☐	☐	☐	☐
Lab/Test Results:	☐	☐	☐	☐	☐
Messages from Physician/Staff:	☐	☐	☐	☐	☐

Patient Signature: _____ Date: _____

HUNTSVILLE
Renal Clinic, P.C.

PATIENT CONTACT INFORMATION SHEET

PATIENT NAME: _____

PATIENT DATE OF BIRTH: _____

Any physician, staff, employee, or representative of Huntsville Renal Clinic, P.C. has my permission to discuss my account and medical conditions which may include symptoms, treatments, diagnosis, test results, medications or any other type of protected health information with the following persons in order to facilitate and coordinate my care, treatment and payment.

Name	Relationship	Phone Number
Name	Relationship	Phone Number
Name	Relationship	Phone Number
Name	Relationship	Phone Number
Name	Relationship	Phone Number

I understand that authorizing the release of my information to the above individual(s) is voluntary and does not affect my access to treatment. I can refuse to sign this form. I can revoke it by writing to Huntsville Renal Clinic, P.C. or by completing a new form at any time. This authorization will remain in effect until I change or revoke it. I understand that if information is shared with the above individual(s) it may be subject to redisclosure by the individual(s).

Patient Signature: _____ Date: _____