Summit Nephrology Medical Group, Inc.

Welcome to our practice. We are committed to providing the best, most comprehensive care possible. Please assist us by providing the following information. All information is confidential and is released only with your consent.

Patient Name **Today's Date**	Date of Birth Sex M / F Age
Marital Status (please circle one) Single Married Divorced Widowed	Parent Name (if patient is a minor)
Patient's Social Security Number (Required)	California Driver's License No.
Home Address	City State Zip
Mailing Address (if different than home)	City State Zip
Home Telephone Number	Work Telephone Number
Occupation	Employer's Name
Employer's Address	City State Zip
Spouse Name Spouse's D.O.B.	Spouse's Employer
Referring Physician	Address Phone / Fax
Primary Care Physician (if different from referring physician)	Address Phone / Fax
PHARMACY NAME	PHARMACY PHONE NUMBER
NOTIFY IN CASE OF EMERGENCY	
Name	Relationship
Address	City State Zip
Home Telephone	Work Telephone
Nearest Relative **(not living with you)**	Address
Home Telephone	Work Telephone
FINANCIAL INFORMATION: PERSON RESPONSIBLE FOR ACCOUNT (if other than patient)	
Name	Telephone
Address	City State Zip
Primary Insurance Company	Claim Address
Subscriber's Name	Subscriber's Date of Birth
Subscriber's SSN#.	Insurance ID No.:
Secondary Insurance Company	Claim Address
Subscriber's Name	Subscriber's Date of Birth
Subscriber's SSN#	Insurance ID No.:

Please Read Our Financial Policy Statement and Agreement on Next Page

Summit Nephrology Medical Group, Inc.

151 N. Sunrise Ave., Ste. 1205
Roseville, CA 95661
916-789-1505

Financial Policy

I understand that I am financially responsible for charges incurred for services rendered. I understand that my insurance will be billed as a courtesy and that I am responsible for any remaining balance, copayments or charges that are denied due to non-coverage. I authorize Summit Nephrology Medical Group, Inc. to bill my insurance and accept payment on my behalf for services rendered.

Name_____ D.O.B. _____

Signature _____ Date _____

Summit Nephrology Medical Group, Inc.

Welcome to our practice! Please take a few minutes and fill out the enclosed medical questionnaire prior to your appointment. By taking the time to provide us this information you will help our physicians to be more comprehensive and efficient during your evaluation. Please fill in information, circle appropriate diagnoses and symptoms and use the blank lines under each heading to provide information that you feel is relevant.

Past Medical History (Please circle):

Diabetes	**Hypertension**	**Coronary Artery Disease**
Stroke	**High Cholesterol**	**Blood Clots**
Peripheral Vascular Disease	**Lupus**	**Arthritis**

Other:_____

_____

Please explain:_____

_____

_____

Surgical History (Include name and date of surgery):

1._____

2. _____

3. _____

4. _____

5. _____

6. _____

Social History:

Marital Status: Married Single Divorced Widowed Other_____

Employment Status:_____

Alcohol (Drinks per day and years used):_____

Tobacco (Packs per day, number of years used and quit date):_____

Patient Name:_____ **Date :**_____

Family History (Please include significant medical history for family members including age of their passing if relevant):

Mother:_____

Father:_____

Siblings:_____

_____

Children:_____

_____

Medication List (Please include dose per pill, number of pills taken and times per day. For example "Metoprolol 50mg tabs, One tablet two times a day":

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

7. _____

8. _____

9. _____

10._____

11. _____

12. _____

13. _____

14. _____

15. _____

Patient Name:_____ **Date :**_____

Allergies (Medications or meaningful environmental allergies): PLEASE list reaction also

1. _____

2. _____

3. _____

4. _____

Review of Systems List

In the last 30 days have you had any history of the following; (please check yes or no)

General	CV
Y N ☐ ☐ Anorexia ☐ ☐ Chills ☐ ☐ Fatigue/weakness ☐ ☐ Fever ☐ ☐ Malaise ☐ ☐ Sleep disorder ☐ ☐ Sweats ☐ ☐ Weight gain ☐ ☐ Weight loss	Y N ☐ ☐ Chest pain ☐ ☐ Dyspnea (shortness of breath) on exertion ☐ ☐ Orthopnea (shortness of breath lying down) ☐ ☐ Palpitations ☐ ☐ Peripheral edema (leg swelling) ☐ ☐ PND (shortness of breath at night) ☐ ☐ Syncope
Resp	**GI**
Y N ☐ ☐ Cough ☐ ☐ Dyspnea at rest ☐ ☐ Excessive sputum ☐ ☐ Hemoptysis (bloody cough) ☐ ☐ Pleurisy (chest pain worse with breathing) ☐ ☐ Wheezing	Y N ☐ ☐ Abdominal pain ☐ ☐ Change in bowel habits ☐ ☐ Constipation ☐ ☐ Diarrhea ☐ ☐ Dysphagia (trouble swallowing) ☐ ☐ Gas/bloating ☐ ☐ Hematochezia (blood in stools) ☐ ☐ Indigestion/heartburn ☐ ☐ Jaundice (yellowing skin) ☐ ☐ Melena (black tarry stools) ☐ ☐ Nausea ☐ ☐ Odyynophagia (pain swallowing) ☐ ☐ Rectal pain ☐ ☐ Vomiting

Patient Name: _____ **Date :** _____

Neuro	Psych
Y N ☐ ☐ Difficulty walking ☐ ☐ Dizziness ☐ ☐ Frequent falls ☐ ☐ Frequent headaches ☐ ☐ Head trauma ☐ ☐ Imbalance ☐ ☐ Vertigo ☐ ☐ Paralysis ☐ ☐ Paresthesias (“pins & needles”) ☐ ☐ Seizure ☐ ☐ Transient blindness ☐ ☐ Tremors	Y N ☐ ☐ Anxiety ☐ ☐ Confusion ☐ ☐ Depression ☐ ☐ Hallucination ☐ ☐ Mania ☐ ☐ Memory loss ☐ ☐ Paranoia ☐ ☐ Phobia
Endo	Heme
Y N ☐ ☐ Cold intolerance ☐ ☐ Hair growth ☐ ☐ Hair loss ☐ ☐ Heat intolerance ☐ ☐ Hyperpigmentation ☐ ☐ Polydipsia (excessive drinking of water) ☐ ☐ Polyuria (excessive urinating) ☐ ☐ Unusual weight change	Y N ☐ ☐ Abnormal bruising ☐ ☐ Bleeding ☐ ☐ Enlarged lymph nodes
Eyes	ENT/Allergy
Y N ☐ ☐ Blurring ☐ ☐ Diplopia (double vision) ☐ ☐ Discharge ☐ ☐ Eye pain ☐ ☐ Glasses ☐ ☐ Irritation ☐ ☐ Photophobia (fear of lights or eye discomfort in light) ☐ ☐ Vision loss	Y N ☐ ☐ Allergic rash ☐ ☐ Decreased hearing ☐ ☐ Ear discharge ☐ ☐ Gingival hyperplasia (gumline growth) ☐ ☐ Chronic sinusitis ☐ ☐ Hay fever ☐ ☐ Hearing aids ☐ ☐ Hoarseness ☐ ☐ Nasal congestion ☐ ☐ Nose bleed ☐ ☐ Recurrent infection ☐ ☐ Sore throat ☐ ☐ Tinnitus (ringing in ears) ☐ ☐ Urticaria (skin wheals on contact or hives)

GU	
Y N ☐ ☐ Abnormal vaginal bleeding ☐ ☐ Amenorrhea (no menstrual period) ☐ ☐ Decreased libido (sex drive) ☐ ☐ Dysuria (painful urination) ☐ ☐ Erectile dysfunction ☐ ☐ Genital sores ☐ ☐ Hematuria (blood in urine) ☐ ☐ Incontinence ☐ ☐ Menorrhagia (heavy menstrual periods) ☐ ☐ Nocturia (urination at night) ☐ ☐ Pelvic pain ☐ ☐ Urinary frequency ☐ ☐ Urinary hesitancy ☐ ☐ Urinary urgency	

OTHER: _____

_____

Thank you again for taking the time to do this. We at Summit Nephrology Medical Group look forward to providing you excellent care!

Patient Signature: _____ **Date Of Birth:** _____

Print Name: _____ **Date :** _____

Medications

Please bring all of your actual medications in their original bottles with you to your appointments. Please include over the counter and herbal or natural remedies as well. Alternatively, you may bring a complete list, including doses and times per day used. Many medications require dose reductions or should be avoided altogether in individuals with chronic kidney disease. We need to know your current medications and their dosages in order to determine what changes may be necessary. Thank you.