New Patient Medical History

Name: ______________________________ Date of Birth: ____/____/________ Sex_______

Address:____

Home Phone( )_____________________Ok to leave a message YES/NO

Cell ( )___________________________ Ok to leave a message YES/NO

☐ If you are on MyChart through your primary doctor, skip to Social and Education

Past Medical History

Condition / Disease	Year Began	Condition / Disease	
☐ Hypertension		Other(s):	
☐ High Cholesterol			
☐ Hypothyroidism (low thyroid)			
☐ COPD, Emphysema, or Asthma			
☐ Diabetes			
☐ GERD			
☐ Depression or Anxiety			

Past Surgical Procedures/ Hospitalizations/ Serious injuries or Fractures

Operation/Hospitalization/Injury	Month/Year	Operation/Hospitalization/Injury	Month/Year

Medication or Food Allergies or Intolerances

Medication/Food	Reaction	Medication/Food	Reaction

Medications, Vitamins, and Herbal Supplements

Medication	Strength	Number of Pills taken & Frequency

Social and Educational History

Marital Status:	Age of Children, if any:
Work Status (Circle one): Employed/ Unemployed Retired / Disabled	Current or Prior Occupation:
Highest level of education:	Hours Worked per week:
What type of exercises do you perform, duration & frequency?	In what type of residence do you live (House, assisted living, nursing home)?
Do you drink alcohol? If yes, what type & how often?	Are you a current smoker? If yes, how many packs per day?

Are you a former Smoker? If yes, what year did you quit? Number of years smoked?	Are you sexually active?

Family Health History

Please list below the health history of your blood (genetic) first degree relatives. Please include any history of kidney disease, kidney transplant, or dialysis.

Relative	Living or deceased	Current age or age at death	Cause of death	Health problems
Father:				
Mother:				
Brother(s):				
Sister(s):				

Review of Systems

Please review the following symptoms and circle those items that are a problem for you

Activity Change	Eye discharge	Urinary Frequency
Appetite Change	Eye itching	Chest tightness
Chills	Eye pain	Cough
Fatigue	Visual disturbance	Shortness of breath
Fever	Cold intolerance	Wheezing
Unexpected Weight Change	Heat intolerance	Chest Pain
Unusual Sweating	Excessive thirst	Leg Swelling
Palpitations	Congestion	Difficulty Urinating
Abdominal Pain	Dental problems	Painful Urination
Abdominal Distention	Drooling	Involuntary Urination
Blood in Stool	Ear discharge	Flank Pain
Constipation	Facial Swelling	Blood in urine
Anal bleeding	Hearing loss	Urine Decreased
Diarrhea	Mouth sores	Penile Pain
Problems walking	Nose Bleeds	Penile Swelling
Joint Swelling	Trouble Swallowing	Penile Discharge
Back Pain	Voice Change	Testicular Pain

Note: This is a confidential record of your medical history and will be kept in this office. Information here will not be released to any person except when you have authorized us to do so.

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I authorize the healthcare staff to perform the necessary health care services I may need.

Patient Signature______________________________________ **Date**__________________

Physician's review signature____

LAKE MICHIGAN
Nephrology

Patient Financial Policy

We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment.
Unless other arrangements have been made in advance by you with our biller or office manager, your co-pay and any outstanding balances are due at time of service or you will need to re-schedule. For your convenience we accept Visa, Mastercard, Discover, American Express, checks, and cash.

Your Insurance

- It is your responsibility to know and understand your coverage and benefits. As a courtesy, we will file your insurance forms from our office. Please make sure your insurance and demographic information is kept up to date with our office. Patients are responsible for all fees that are not covered by insurance, including co-payments, coinsurance, deductibles and non-covered services.

- If you have insurance coverage with a plan for which we do not have a prior agreement, we will prepare and submit the claim for you on an assigned basis. You will be responsible for your portion and also any payments your insurance may deny.

- In the event that your health plan determines a service to be "not covered," you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.

- We will bill your health plan for all services provided in the hospital. Any balance due is your responsibility and is due upon receipt of a statement from our office.

Self Pay

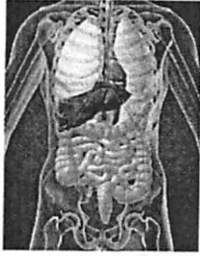
- Payment is due at time of service unless other arrangements have been made in advance by you with our biller or office manager.

I have read and understand the financial policy of the practice, and I agree to the terms. I also understand and agree that the practice may amend such terms from time to time.

____
Printed Name of the Patient

____ ____________________
Signature of Patient or Responsible Party Date

Updated 4/9/18



Lake Michigan Nephrology

HIPAA Privacy Notice and Acknowledgement

I acknowledge that I have received the attached Notice of Privacy practices.

______________________________________ ____________________

Patient or Personal Representative Signature Date

If personal representative's signature appears above, please describe personal

Representatives relationship to the patient:

____

Persons We May Speak To Regarding Your Health

First name **Last Name** **Relationship**

(1)____

(2)____

(3)____

(4)____

ASSIGNMENT OF BENEFITS	RELEASE OF INFORMATION
I authorize payment of Medical benefits to myself or the named provider for professional services rendered	I authorize the release of any medical information necessary to process this claim
Signed____________________ (Subscriber)	**Signed**____________________ (Patient, or parent if minor)
Date____________________	**Date**____________________