Internal Medicine & Nephrology Associates, P.A.

New Patient Information

Last Name: ____________________________ First Name: __________________________________ MI: ________

Address: ____

City: ___________________________________ State: __________________________ Zip Code: _____________

Home Phone: __________________________________ Mobile Phone: ___________________________________

Email: ____

Date of Birth: _________________ Age:_______ Sex:____________ Marital Status: ________________________

Social Security Number: _________________ Employer: ____

Spouse's Name: ____ Date of Birth: _____________________

Social Security Number: ___________________ Employer: ____

Emergency Contact (Name, Relation, Phone Number)

1. ____
2. ____

Insurance Information

Primary

Name of Insurance: ____________________________________ Insured's Name: ___________________________

ID/Policy Number: ____________________________________ Group Number:___________________________

Copay: ______________ Deductible: ______________ Have you met your deductible? ______________________

Secondary

Name of Insurance: ____________________________________ Insured's Name: ___________________________

ID/Policy Number: ____________________________________ Group Number:___________________________

Copay: ______________ Deductible: ______________ Have you met your deductible? ______________________

I authorize Internal Medicine & Nephrology Assoc, P.A. to release any medical information necessary to process claims for the services provided. I authorize payment of government/medical benefits to Internal Medicine & Nephrology Assoc, P.A. for services provided. I understand that I remain responsible for any and all charges not met by my insurance company.

Please be aware that we <u>DO NOT</u> write prescriptions for any narcotics or pain medications.

If necessary, we will refer you to pain management.

Signature: ____ **Date:** ________________________

Patient Name: ____ **Date of Birth:** ____________________

Allergies To Medications
(Describe allergy or reaction)

Immunizations
(Check Those Received)

✓	VACCINE	YEAR
	Tetanus	
	Hepatitis A	
	Hepatitis B	
	Pneumonia	
	MMR	
	Polio	
	Chicken Pox	

Past Medical History
Check (✓) conditions you have or have had

Condition	Yes	Year	Condition	Yes	Year	Condition	Yes	Year
Alcoholism			Gall Bladder Disease			Malaria		
Anemia			Glaucoma			Measles		
Anorexia			Goiter			Migraine		
Appendicitis			Gonorrhea			Mumps		
Arthritis			Gout			Pneumonia		
Asthma			Heart Disease			Polio		
Bleeding Disorder			Heart Murmur			Prostate Problems		
Breast Lump			Hemorrhoids			Psychiatric Care		
Bronchitis			Hepatitis			Rheumatic Fever		
Bulimia			Hernia			Skin Disease		
Cancer Type:			Herpes			Stomach Ulcers		
Cataracts			High Blood Pressure			Stroke		
Chicken Pox			High Cholesterol			Syphilis		
Depression			HIV Positive			TB Skin Test (+)		
Diabetes			Kidney Disease			Tuberculosis		
Emphysema			Liver Disease/Jaundice			Thyroid Disease		
Epilepsy or Seizures			Low Back Pain					

Injuries and Operations

Type	Year	Type	Year

Medication (Include over the counter), Vitamins, Herbs, and Other Therapies

Name	Dose	Times per day

Patient Name: ______________________________ Date of Birth: ____________

Family History				
Relative	Age	Health Status	Age of Death	Illness
Mother				
Father				
Brothers				
Sisters				

Check (✓) if your blood relatives have had:		
✓	Disease	Relation To You
	Ovarian Cancer	
	Bleeding Tendency	
	Breast Cancer	
	Colon Cancer	
	Depression	
	Diabetes	
	Heart Disease	
	High Blood Pressure	
	Other:	

Health Habits

Check (✓) which substances you use and describe how much you use.

✓	Substances	How much?	Tobacco Use	Yes	No
	Caffeine		Do you currently smoke or chew tobacco?		
	Alcohol		Have you ever smoked or chewed tobacco?		
	Cocaine, Heroin, Marijuana, Etc		Pack(s) per day ___ for ____ years		

Exercise and Diet

Exercise and Diet
Do you exercise regularly? ☐Yes ☐No
Type of exercise?
Do you follow a special diet? ☐Yes☐ No
Type of diet?

Sexual Contacts

Sexual Contacts
Are you sexually active? ☐Yes ☐No
If yes, do you have sex with: ☐Men ☐Women ☐Both

Women's Health

Date of last period?	Did you have diabetes during your pregnancy? ☐Yes ☐No
Date of last PAP smear?	Number of Pregnancies:
Date of last mammogram?	Number of Births:
Have you ever been pregnant? ☐Yes ☐No	

List symptoms you are having:

Do you have a living will or durable power of attorney for healthcare? ☐Yes ☐No
If yes, please attach a copy.

Patient Signature: ______________________________ Date: ____________

Elias Kanaan, M.D.
Hung Bui, M. D
Mary Norris, NPC

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Consent for Treatment

I authorize and direct Internal Medicine & Nephrology Associates, P.A. to perform quality care upon me.

I acknowledge that the practice of medicine is not an exact science and that no guarantees have been made to me as the outcome of the procedures and/or treatments.

I grant this consent without duress, confusion, or pressure from my physician, and/or his staff, associates, or colleagues.

Patient Name: ____ Date: ____________________

Witness Signature: ____________________________________ Date: ____________________

If patient is a minor (less than 18 years of age) or has legally designated representative:

Responsible Party Signature:_________________________________ Date:______________

Patient Financial Policy Sheet

To reduce confusion and misunderstanding between our patient and practice, we have adopted the following financial policies. If you have any questions regarding these policies, please discuss them with our office manager. 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 either you or your health insurance carrier, full payment is due at the time of service. For your convenience we accept cash, check, Master Card, and Visa.

Your Insurance

- **We have made prior arrangements with many insurers and health plans to accept an assignment of benefits. This means that we will bill those plans for which we have an agreement and will only require you to pay the authorized copayment at the time of service. This office's policy is to collect this copayment when you arrive for your appointment.**
- **If you have insurance coverage with a plan for which we do not have a prior agreement, we will prepare and provide you with a receipt so that you may seek payment from your insurer. Consequently, the charges for your care and treatment are due at the time of the service.**
- **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.**

Minor Patients

- **For all services rendered to minor patietns, we will look to the adult accompanying the patient and the parent or guardian with custody for payment.**

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

______________________________	______________________________
Printed Name of the Patient	**Date of Birth**
______________________________	______________________________
Signature of Patient or Responsible Party	**Date**

NOTICE OF PRIVACY PRACTICES
AUTHORIZATION FORM

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you that you receive at Internal Medicine & Nephrology Associates, P.A.

I have received this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document upon request.

______________________________	______________________
Printed Name of the Patient	**Date of Birth**
______________________________	______________________
Signature of Patient or Responsible Party	**Date**

Please list any immediate family member (spouse, parent, child) and relationship that protected health information may be disclosed to:

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