



PATIENT INTAKE FORM

Disclaimer: Thank you for your interest in being a patient of South Florida Renal Care. This form is used to collect information about new patients and used for internal purposes only. The information you supply is confidential and will be treated accordingly.

PATIENT DETAILS

First Name: _____ Last Name: _____

Date of Birth: _____ Gender: ☐ Male ☐ Female ☐ Other

Street Address: _____

City: _____ State: _____ ZIP Code: _____

Home Phone: _____ Mobile Phone: _____

Social Security Number: _____ E-Mail: _____

Ethnicity/Race: _____ Weight: _____ Height: _____

Primary Language: ☐ English ☐ Spanish ☐ Other: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Spouse Name: _____ Spouse Phone: _____

EMERGENCY CONTACT

Emergency Contact Name: _____

Relationship: _____ E-Mail: _____

Home Phone: _____ Mobile Phone: _____

PRIMARY INSURANCE POLICY

Primary Insurance Company: _____

Group #: _____ ID #: _____

Primary Insurance Type: ☐ HMO ☐ PPO ☐ Medicare ☐ Other: _____

Complete the following if you are **not** the policyholder for your primary insurance:

Insurance Policyholder: ☐ Spouse ☐ Child ☐ Parent ☐ Other: _____

Policyholder Name: _____ Date of Birth: _____

Policyholder Social Security Number: _____

SECONDARY INSURANCE POLICY (IF ANY)

Secondary Insurance Company: _____

Group #: _____ ID #: _____

Primary Insurance Type: ☐ HMO ☐ PPO ☐ Medicare ☐ Other: _____

Complete the following if you are **not** the policyholder for your secondary insurance:

Insurance Policyholder: ☐ Spouse ☐ Child ☐ Parent ☐ Other: _____

Policyholder Name: _____ Date of Birth: _____

Policyholder Social Security Number: _____

TREATING PHYSICIANS

Primary Care Physician: _____ **Phone:** _____

List all other active treating physicians:

Physician Name: _____ **Specialty:** _____

Physician Name: _____ **Specialty:** _____

Physician Name: _____ **Specialty:** _____

Physician Name: _____ **Specialty:** _____

ALLERGIES

List your allergies and describe the reactions to your body:

Allergy: _____ **Reaction:** _____

Allergy: _____ **Reaction:** _____

Allergy: _____ **Reaction:** _____

Allergy: _____ **Reaction:** _____

MEDICATION

List the medications you are currently taking including the dosage:

Medication: _____ **Dose:** _____

Medication: _____ **Dose:** _____

Medication: _____ **Dose:** _____

Medication: _____ **Dose:** _____

FAMILY HEALTH HISTORY

List any major conditions/illnesses that your immediate family members have had:

| Relative | Condition | Living? | If deceased, at what age? |
|----------|-----------|---|------------------------------|
| Mother | | <input type="checkbox"/> Y <input type="checkbox"/> N | |
| Father | | <input type="checkbox"/> Y <input type="checkbox"/> N | |
| Sibling | | <input type="checkbox"/> Y <input type="checkbox"/> N | |
| Other: | | <input type="checkbox"/> Y <input type="checkbox"/> N | |
| Other: | | <input type="checkbox"/> Y <input type="checkbox"/> N | |

SURGICAL HISTORY

List any surgeries, fractures, major illnesses, or hospitalizations that you have had:

| Description | Doctor | Location | Year |
|-------------|--------|----------|------|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

MEDICAL HISTORY

Have you ever had any of the following?

| | | | |
|------------------------------|---|--------------------------|---|
| Anemia | <input type="checkbox"/> Y <input type="checkbox"/> N | Hypertension | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Arthritis Conditions | <input type="checkbox"/> Y <input type="checkbox"/> N | Male Hypogonadism | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Asthma | <input type="checkbox"/> Y <input type="checkbox"/> N | Hypothyroidism | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Atrial Fibrillation | <input type="checkbox"/> Y <input type="checkbox"/> N | Infection Problems | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Bleeding Problems | <input type="checkbox"/> Y <input type="checkbox"/> N | Insomnia | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Benign Prostatic Hyperplasia | <input type="checkbox"/> Y <input type="checkbox"/> N | Irritable Bowel Syndrome | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Coronary Artery Disease | <input type="checkbox"/> Y <input type="checkbox"/> N | Kidney Problems | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Cancer | <input type="checkbox"/> Y <input type="checkbox"/> N | Menopause | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Cardiac Arrest | <input type="checkbox"/> Y <input type="checkbox"/> N | Migraines/Headaches | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Celiac Disease | <input type="checkbox"/> Y <input type="checkbox"/> N | Neuropathy | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Chest Pain | <input type="checkbox"/> Y <input type="checkbox"/> N | Onychomycosis | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Congestive Heart Failure | <input type="checkbox"/> Y <input type="checkbox"/> N | Organ Injury | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Chronic Fatigue Syndrome | <input type="checkbox"/> Y <input type="checkbox"/> N | Osteoporosis | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Depression | <input type="checkbox"/> Y <input type="checkbox"/> N | Pulmonary Embolism | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Diabetes | <input type="checkbox"/> Y <input type="checkbox"/> N | Seizure Disorders | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Drug/Alcohol Abuse | <input type="checkbox"/> Y <input type="checkbox"/> N | Shortness of Breath | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Erectile Dysfunction | <input type="checkbox"/> Y <input type="checkbox"/> N | Sinus Conditions | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Fibromyalgia | <input type="checkbox"/> Y <input type="checkbox"/> N | Stroke | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Gerd | <input type="checkbox"/> Y <input type="checkbox"/> N | Syndrome X | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Heart Disease | <input type="checkbox"/> Y <input type="checkbox"/> N | Tremors | <input type="checkbox"/> Y <input type="checkbox"/> N |

Hyperinsulinemia
Hyperlipidemia

☐ Y ☐ N
☐ Y ☐ N

Wheat Allergy

☐ Y ☐ N

List any other medical problems that you have had: _____

HEALTH CONCERNS

What's your primary health concern? _____

Approximately when did this issue begin? _____

Does the issue cause you pain? ☐ Yes ☐ No

- If so, where? _____

How has the pain changed since it began? ☐ Increased ☐ Decreased ☐ Unchanged

How quickly did you current pain begin? ☐ Gradually ☐ Suddenly

How often does your pain occur? ☐ Constantly ☐ Occasionally ☐ Rarely

When is your pain at its worst? ☐ Morning ☐ Afternoon ☐ Evening ☐ Night

What are your current symptoms? _____

Check any of the following that describe your pain:

| | | | | | | | |
|-------------|--------------------------|------------|--------------------------|----------------|--------------------------|-------------------|--------------------------|
| Aching | <input type="checkbox"/> | Numbness | <input type="checkbox"/> | Spasming | <input type="checkbox"/> | Throbbing | <input type="checkbox"/> |
| Cramping | <input type="checkbox"/> | Shock-like | <input type="checkbox"/> | Squeezing | <input type="checkbox"/> | Tingling | <input type="checkbox"/> |
| Dull | <input type="checkbox"/> | Shooting | <input type="checkbox"/> | Stabbing/Sharp | <input type="checkbox"/> | Tiring/Exhausting | <input type="checkbox"/> |
| Hot/Burning | <input type="checkbox"/> | | | | | | |

List any other health concerns that you would like us to know about:

SOCIAL HISTORY

Do you currently consume alcohol? ☐ Yes ☐ No

- How many drinks per week? _____

Do you currently smoke? ☐ Yes ☐ No

- What do you smoke? ☐ Tobacco ☐ Marijuana ☐ Other: _____
- How many cigarettes do you smoke per day? _____

Do you currently use any other drugs? ☐ Yes ☐ No

- What other drugs do you take? _____
- How often? ☐ Daily ☐ Weekly ☐ Occasionally ☐ Rarely

Do you drink caffeine? ☐ Yes ☐ No

- How many cups per day? _____

How frequently do you exercise? ☐ Daily ☐ Weekly ☐ Occasionally ☐ Rarely

Are you on a special diet? ☐ Yes ☐ No

- What diet? _____

PREFERRED PHARMACY

Pharmacy Name: _____ **Phone:** _____

Street Address: _____

City: _____ **State:** _____ **ZIP Code:** _____

PATIENT CONSENT

By signing below, I hereby acknowledge, agree, and authorize all of the following:

- Accurate Information.** I certify that the information provided on this form is accurate, complete, and up to date to the best of my knowledge.
- Patient Rights and Responsibilities.** I understand that the healthcare facility maintains a Notice of Privacy Practices, which describes how my protected health information may be used and disclosed, and how I may access my health records. I understand that I have the right to review this healthcare facility's Notice of Privacy Practices prior to signing this form.
- Release of Medical Information.** I authorize the release of my health information to the healthcare facility in accordance with the healthcare facility's Notice of Privacy Practices. This includes, but is not limited to, releasing medical information to my referring physician, primary care physician, and any physician(s) I may be referred to. The healthcare facility shall ensure all health information remains confidential, as required by HIPAA, and will not release any of my health information without my consent.
- Consent for Treatment.** I grant the healthcare facility, including its affiliated providers, physicians, and other medical personnel, permission to use the health information provided for the purpose of my medical treatment as necessary.

- e) **Consent to Communication.** I consent to receiving communications from the healthcare facility regarding appointment reminders, test results, and other necessary healthcare-related information via phone, email, or channels.
- f) **Acknowledgment.** By signing below, I hereby acknowledge, agree, and authorize all of the above, and I authorize the healthcare facility to retrieve and review my medical history and authorize the healthcare facility to release the information required in obtaining procedure authorization or the processing of any insurance claims.

Patient Signature: _____ **Date:** _____

Print Name: _____