



## 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: \_\_\_\_\_

## 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

Y  N    Wheat Allergy

Y  N

Hyperlipidemia

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: \_\_\_\_\_