KANSAS CITY
KIDNEY SPECIALISTS

Kansas City Kidney Specialists, PA
11661 College Blvd. Suite 100
Overland Park, KS 66210
913-495-5517(Phone)
913-495-5518 (fax)

Tarek Darwish, MD, FACP
Richard Capling, DO
Danielle Shockley, APRN, AANP-C

NEW PATIENT PACKET

Patient Name:		Gender: M____ F____
Date of Birth:	Race:	Marital Status: S M W D
Social Security:	Email:	
Home Phone:	Cell Phone:	Work Phone:
Address:		
City:	State:	Zip:
LIVING WILL YES___ NO	Durable Power of Attorney YES NO	

Primary Care Physician: Address: _____	Phone: _____ Fax:_____
Referring Physician: _____ Address: _____	Phone: _____ Fax: _____
Pharmacy Name: _____ Address: _____	Phone: _____ Fax: _____

EMERGENCY CONTACT:		PHONE:
Name:		Home
Address:		Work
Relationship to Patient:		Cell

Primary Insurance Information:	Referral Yes____ No ____
Name:	Phone:
Subscriber Name:	DOB: _____
Policy Number:	Co-Pay Yes____ ($) No ____
Mail Order Pharmacy:	Phone:

Patient Name: _____ Date of Birth: _____

Secondary Insurance Information:	
Name:	Phone:
Subscriber Name:	DOB: _____
Policy Number:	

Appointment Date:	Time:

Please bring to every appointment: Complete Medication List, Photo ID, Insurance Cards, Co-payment.

Review of Systems

Are you currently having problems with any of the following area (circle or write in comment).

Cardiovascular	**Constitutional**	**Ears, Nose & Throat**
Chest pain	Night sweats	Facial numbness
Dizziness	Decreased appetite	Hearing loss
Edema __ankles __legs	Decreased energy	Nose bleeds
Fatigue		Sinus infections
Endocrine System	**Eyes**	**Gastrointestinal**
Feel cold	Blurry vision	Abdominal pain
Feel warm	Cataracts	Blood in stool
Facial flushing	Decrease in vision	Heartburn
Appetite altered	Double vision	Nausea
		Vomiting
		Diarrhea
Genitourinary	**Lymph / Immune System**	**Musculoskeletal**
Bloody urine	Anemia	Back pain
Pain or difficulty urinating	Fatigue	Joint pain
Kidney stones	Hormone therapy	Limited in motion
Pelvic pain	Previous transfusions	

Patient Name: _____ Date of Birth: _____

Neurology	**Psychiatric**	**Respiratory**
Clear speech	Depression	Cigarette smoking _____ years
Fainting spells	Memory loss	Congestions
Tremors	Mood swings	Cough
Vertigo		Shortness of breath always or on exertion

Skin

Dryness

Hair thinning

Itching

Other comments: _____

_____

Height: _____ **Weight:** _____

Past Medical History

Check all that apply:

___Heart Disease	___Arthritis	___High Blood Pressure # years____
___Kidney Stones	___Rheumatoid Arthritis	Controlled ___ Uncontrolled ___
___Thyroid Disease	___Ulcers ____Area of Ulcers	___Diabetes # years____
___High Cholesterol	___Problems with urination	Controlled ___ Uncontrolled ___
___Liver Disease	___Bowel – Type_____	___Cancer-Type _____
___Autoimmune Disorders	___Seizures ___Lupus	___Lungs

Surgical & Hospitalization History		
Surgery or Hospitalization	Month and Year	Physician performing surgery

Patient Name: _____ Date of Birth: _____

Please list all of the medications you are taking. Include over the counter medications, herbs, vitamins.

Medication	Dosage	How often	Medication	Dosage	How often

Please list ALLERGIES to medications and your reaction.

Any reaction to: Shellfish ____ IV Contrast Dye ____ Penicillin ____

Medication	Reaction

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INFORMATION AND ASSIGNMENTS OF BENEFITS

I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original.

I hereby authorize the above provider to apply for benefits on my behalf for covered services rendered by him or by his order. I request that payment from my insurance company be made directly to the above provider (or the party that accepts assignments).

I certify that the information I have reported with regard to my insurance coverage is correct.

I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or my insurance company at any time in writing.

I request that payment of authorized Medicare benefits be made either to me or on my behalf to the above provider for any services furnished to me by physician or supplier. I authorize any holder of medical information needed to determine these benefits or the benefits payable for related services.

Signature: _____ Date: _____

Patient Name: _____ Date of Birth: _____

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AUTHORIZATION TO RELEASE INFORMATION

In the practice of nephrology, we contact patients regarding appointments, scheduling, billing, and /or payment questions on your account, results of test, etc. In addition, unforeseeable emergencies do sometimes arise when it may be necessary for the physician or staff to contact you. It is our office policy to leave a message at home if you are not available or we may need to contact you at work if an emergency arises.

	(Please circle one)	
May we contact you at home?	YES	NO
May we contact you at work?	YES	NO
May we leave a message on your answering machine at home?	YES	NO
May we leave a message at your work place?	YES	NO

EMERGENCY CONTACT

Please give the name and phone number of a relative or friend not living with you whom we may contact in the event of a medical emergency.

Name: _____ Phone: _____ Relationship: _____

AUTHORIZATION TO RELEASE INFORMATION

This office adheres to strict policies with regard to release of confidential information. I understand that your policy in not to disclose any personal health information to other parties, except those directly involved in my care, without my written authorization or a permitted by law. For this reason, I authorize you to discuss and disclose my personal health information to the person(s) named below for the purpose of assisting with or facilitating my care.

AUTHORZED REPRESENTATIVE

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

I understand that I have the right to limit the information that you release under this authorization. For example, I may limit my Authorized Representative's access to information about a particular diagnosis/disease. Any such limitations must be described in writing. I understand that by leaving this section BLANK, I am creating no limitations of disclosure.