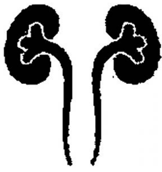


Kidney Associates of Texas

McKinney Office: 4510 Medical Center Drive, Suite 202, McKinney, TX 75069
Sherman Office: 305 N Highland Ave, Sherman, TX 75092

Phone: 972-521-6000 Fax: 972-521-6012
www.kaotexas.com

PATIENT INFORMATION

Name ______________________________ SSN ____________________ ☐Male ☐ Female

Address ______________________________ City ____________________ State ________ Zip· __________

Age: __________ DOB: ____________________ Phone: ____________________ Alternate Phone: ____________________

☐ Married ☐ Single ☐ Divorced ☐ Widowed

Employer Name: ____________________ Address ______________________________

☐ Full-Time ☐ Part-Time ☐ Retired ☐ Self-Employed Student- Full-Time ☐ Student- Part-Time ☐

Primary Care Physician ______________________________ Phone ______________________________

Referring Physician (If different from PCP): ____________________ Phone: ______________________________

EMERGENCY CONTACT Name: ____________________ Phone: ____________________ Relationship: __________

PHARMACY NAME: ____________________ LOCATION: ____________________ PHONE: ____________________

INSURED PARTY

Name ______________________________ Relationship to Insured ______________________________

Address ______________________________ City ____________________ State __________ Zip ________

Age: ____________ DOB: ____________________ Phone: ____________________ Alternate Phone: ____________________

Employer Name ______________________________ Address ______________________________

Insurance Information (Copies of Insurance card and Drivers License required)

Credit Card On File Information Below:

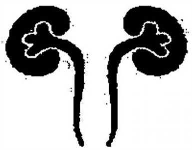
Sign and complete below to authorize Kidney Associates of Texas to make a one time charge to your credit card listed below. By signing this form, you give us permission to charge your credit card on file. This is permission for a single transaction only, and does not provide authorization for any additional unrelated debts or credits to your account.

I, ______________________________ authorize Kidney Associates of Texas to charge my credit card account listed below.

Credit Card Number: ______________________________ Expiration Date: ______________

C V V Code ______________

Signed ____ Date ______________________________



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HEALTH HISTORY FORM

PATIENT NAME:________________________________DATE OF BIRTH:______________________________

PAST MEDICAL HISTORY (Please Check mark all that apply)

☐ High Blood Pressure (Hypertension)
☐ Previous Kidney Disease/ CKD
☐ Stroke/TIA
☐ Heart Disease
☐ Kidney Stones
☐ CHF
☐ Diabetes- I I Type 1 I I Type 2 I I Type 2 on Insulin

[] Hearing Problems [ ] Blindness [ ] Cataract [] Retinopathy [ ] Right/left [ ] Laser Surgery Right/Left

[] COPD [] Irregular Heart Beats [ ] Coronary Artery Stent

[ ] Stomach Ulcers [ ] Colon Cancer [ ] Hepatitis [ ] Asthma [ ] Gout [ ] Recurrent Kidney/Bladder Infections
[] Prostate Disease [ ] UTI [ ] Epilepsy/Seizures [ ] Thyroid Disease [] High Cholesterol

[] Rheumatoid Arthritis [] Osteoarthritis [ ] Lupus [ ] Skin Disorder

[] Osteoporosis [ ] Anxiety [] Anemia ([ ] Due to Iron Deficiency [ ] Chronic Kidney Disease [ ] Unknown) [ ] Cancer)
[] OTHER: ____

PAST SURGICAL HISTORY (Please Check mark all that apply)

Surgeries: ( )None ( )Appendectomy ( )AVF/AVG ( )Coronary Artery Bypass ( )Transplant
( )Cataract Surgery ( )Gall Bladder ( )Left Hip Surgery ( )Right Hip Surgery ( )Hysterectomy
( )Right Knee Surgery ( )Left Knee Surgery ( )Kidney

FAMILY HISTORY

Father: ( )Living( )Deceased( )NoSignificantHistory ( )Diabetes( )Heart-Attack( )CHF( )Kidney Failure( )High Blood Pressure( )Cance( )Stroke Mother: [ )Living( )Deceased( )No Significant History( )Diabetes( )Heart Attack( )CHF( )Kidney Failure( )High Blood Pressure( )Cancer( )Stroke

SOCIAL HISTORY

Smoking: [ ] Yes [ ] No [ ] Quit: When did you quit: _____How many years did you smoke: ___ Number of Packs/ Day:_____ Alcohol: [ ] Yes [ ] No [ ] Social [ ] Heavy [ ] Quit
H/O N Drug Abuse: [ ] Yes [ ] No
Marital Status: [ ] Married [ ] Single [ ] Widowed [ ] Divorced

CHECK IF YOU EXPERIENCE ANY PROBLEMS:

◻Burning with Urination	◻Straining to Urinate	◻Leaky Bladder	◻Fever/Chills	◻Irregular Heart Rate
◻Nausea and Vomiting	◻Weak Urine Stream	◻Diarrhea	◻Balance problems	◻Sinus Problems
◻Chest pain	◻Constipation	◻Dizziness or Vertigo	◻Night Sweats	◻Nosebleeds
◻Wheezing	◻Palpitation	◻Persistent Cough	◻Leg pain or cramps	◻Blurry Vision
◻Bone or Joint Pain	◻Shortness of Breath	◻Headaches	◻Confusion	◻Excessive Thirst
◻Weight gain	◻Muscle pain or weakness	◻Urinating Often	◻Urine Smell	◻Abdominal Pain
◻Weight loss	◻Blood in Urine	◻Kidney Stones	◻Night Sweats	◻Swelling in hands/feet
◻Foamy Urine	◻Claudication	◻Back Pain	◻Excess Fatigue	◻Excess Urination

KIDNEY ASSOCIATES OF TEXAS

Patient Registration Form

Disclosures & Consents & Financial Responsibility Agreement

Patient Name: ___________________________________ **Date of Birth:** ______________

ASSIGNMENT OF INSURANCE BENEFITS:
I hereby authorize direct payment of my insurance benefits to Kidney Associates of Texas or the physician individually for services rendered to my dependents or me by the physician or under his-her supervision. I understand that it is my responsibility to know my insurance benefits and whether or not the services I am to receive are covered benefit. I understand and agree that I will be responsible for any co-pay or balance due. It is my responsibility to obtain any Prior Authorizations or Referrals needed for Specialist appointment.

MEDICARE/ MEDICAID/ INSURANCE BENEFITS:
I certify that the information given by me in applying for payment under these programs is correct. I authorize the release of any of my or my dependent's records that these programs may request. I hereby direct that payment of my or my dependent's authorized benefits be made directly to the Kidney Associates of Texas or the physician on my behalf.

NO SHOW OR SAME DAY CANCELLATION FEES:
We understand that occasional missed appointments can occur for a variety of reasons. When you miss an appointment without canceling, someone else who could have been seen in your place is delayed unnecessarily. No-show/Late Cancellation is defined as missing an appointment without canceling at least 24 hours in advance. There will be a $35 Same day cancellation fee and a $50 No-show fee. After the 2nd time, your credit card on file will be charged for the above listed fees. Please be aware that after multiple offenses may result in being discharged from our practice.

AUTHORIZATION TO MAIL, CALL, OR EMAIL:
I certify that I understand the privacy risks of the mail, phone calls, and e-mail. I hereby authorize the Kidney Associates of Texas staff or my physician to mail, call, or e-mail me with communications regarding my healthcare, including but not limited to such things as appointment reminders, referral arrangements, and laboratory results. I understand that I have the right to rescind this authorization at any time by notifying Kidney Associates of Texas to that effect in writing.

FINANCIAL RESPONSIBILITY AGREEMENT:
I understand and agree that I will be financially responsible for any and all charges not paid by my insurance for my visits. This includes medical service or visit, lab testing, and any other screening service or diagnostic ordered by the physician or staff. I understand and agree it is my responsibility and the responsibility of the physician or clinic to know if my insurance will pay for medical service or visit. I understand and agree it is my responsibility to know if my insurance has any deductible, co-payment, coinsurance, usual and customary limit and I agree to make full payment. I understand and agree it is my responsibility to know if the physician or provider I am seeing is contracted in-network with my insurance plan. If the physician I am seeing is not recognized by my insurance company or plan, it may result in claims being denied or higher out of pocket expense to me and I understand this and agree to be financially responsible and make full payment.

Patient signature:___________________________________ **Date:**_________________________

Guarantor signature: ________________________________ **Date:**_________________________
(If different from patient)

Guarantor name (please print):____

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

Allergies to Medications: [ ] No [ ] Yes (if YES please Explain)

____

Do you take any of following: (Circle what applies to you)

TYLENOL MOTRIN IBUPROFEN ALEEVE NAPROXEN MOBIC HERBALS

YOUR CURRENT MEDICATION LIST

Name Of Medication (as it appears on the Bottle)	Dosage:	How Much Taken:	How Many Times Taken Daily:
(example) Aspirin	81 Mg	1 Tablet	Once a Day