# PATIENT INFORMATION

Please print clearly and complete all blanks

DATE:_____ REFERRED BY:_____ SEX:_____

NAME:_____ BIRTHDATE:_____
LAST FIRST MIDDLE

MAILING ADDRESS:_____
CITY STATE ZIP

TELEPHONE:_____ CELL PHONE:_____ WORK NUMBER:_____

SS #_____ MARITAL STATUS:_____ EMAIL:_____

EMPLOYER:_____ OCCUPATION:_____

EMPLOYER'S ADDRESS:_____

**********

RACE (circle one): AMERICAN INDIAN – ALASKAN – ASIAN – BLACK – WHITE – HISPANIC

SMOKER STATUS (circle one): EVERY DAY – SOME DAYS – FORMER – NEVER

RELIGION:_____

**********

NEXT OF KIN:_____ BIRTHDATE:_____

ADDRESS IF DIFFERENT:_____
ADDRESS CITY STATE ZIP CODE

RELATIONSHIP:_____ MALE_____ FEMALE_____ TELEPHONE:_____

**********

EMERGENCY CONTACT:_____

ADDRESS IF DIFFERENT:_____
ADDRESS CITY STATE ZIP CODE

RELATIONSHIP:_____ MALE_____ FEMALE_____ TELEPHONE:_____

**********

RESPONSIBLE PARTY FOR BILLING (if other than patient):

NAME:_____ RELATIONSHIP TO PATIENT:_____

ADDRESS:_____
ADDRESS CITY STATE ZIP CODE

SS #:_____ BIRTHDATE_____ TELEPHONE:_____

**********

PRIMARY INSURANCE:_____ ID#:_____ GROUP#_____

NAME OF INSURED:_____ INSURED'S BIRTHDATE:_____

SECONDARY INSURANCE:_____ ID#_____ GROUP#_____

NAME OF INSURED:_____ INSURED'S BIRTHDATE:_____

All professional services rendered are charged to the patient's account. Necessary forms will be completed to expedite insurance claims for those plans which the physician files. The patient is responsible for all fees, regardless of insurance coverage.

I hereby assign to the physician all payments for medical services rendered and authorize the physician to release any medical information necessary to process claims and request payments from insurance companies or Medicaid payers. A photocopy of this assignment and authorization shall be considered as valid as the original.



SIGNATURE:_____ DATE:_____

# Tahlequah Medical Group
# Nephrology

1373 East Boone St, Suite 1201
Tahlequah, OK 74464

**Name** **Birthdate** / / **Date:** / /

**MEDICAL HISTORY** Check (✓) the medical conditions you have or have had

- ☐ AIDS / HIV positive
- ☐ Anemia
- ☐ Anorexia / Bulimia
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding disorders
- ☐ Blood in Urine
- ☐ Bronchitis
- ☐ Cancer **(Type in Detail)**

  _____

  _____
- ☐ Chemical Dependency
- ☐ Chronic Kidney Disease
- ☐ Congestive Heart Failure
- ☐ Coronary Artery Disease
  Stents or Balloon Angioplasty
- ☐ Diabetes Type?_____
  On Insulin **Y** or **N**
  Duration_____
- ☐ Emphysema
- ☐ Enlarge Prostate
- ☐ Epilepsy
- ☐ Gall Bladder Disease
- ☐ Goiter
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia Site?_____
- ☐ Hypertension
  Duration_____
- ☐ Hypo or Hyperthyroidism
- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Liver Disease
- ☐ Migraine headaches
- ☐ Multiple Sclerosis
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Prostate Cancer
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Suicide attempt
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Ulcers Where?_____
- ☐ Other _____

  _____

**PAST SURGICAL HISTORY**

| Type of Surgery | Year | Type of Surgery | Year |
|---|---|---|---|
| Appendectomy | | Hip Surgery | Right Left |
| Colon Surgery | | Back Surgery | |
| Cholecystectomy | | Other | |
| CABG……Vessel | | | |
| CABG……Vessel | | | |
| Kidney Biopsy | | | |
| Thyroid Surgery | | | |
| Hysterectomy | | | |
| C-Section # | | | |
| Knee Surgery | Right Left | | |

Have you ever had a blood transfusion? ☐ Yes ☐ No If yes, give approximate date: _____

**FAMILY HISTORY** (Fill in health information about your family.) **PLEASE CHECK IF ADOPTED** ☐

| | Age | State of Health | Age at Death | Cause of Death | | Age | State of Health | Age at Death | Cause of Death |
|---|---|---|---|---|---|---|---|---|---|
| Father | | | | | Mother | | | | |
| Brothers | | | | | Sisters | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |

Check (✓) if your blood relatives had any of the following. **(Please indicate who)**

- ☐ Arthritis, Gout_____
- ☐ Cancer_____
- ☐ Diabetes_____
- ☐ Dialysis(WHO)_____
- ☐ Heart Disease, Strokes_____
- ☐ High Blood Pressure_____
- ☐ Kidney Disease_____
- ☐ Kidney Stones_____
- ☐ Tuberculosis_____
- ☐ COPD_____
- ☐ Thyroid_____
- ☐ Other

Anything else you feel the doctor needs to know?_____

_____

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his staff responsible for any errors or omissions that I may have made in the completion of this form. I consent to examination/treatment/surgery if indicated by the physicians of Northeastern Health Systems.

Signature:_____ Date:_____