Patient Information(PLEASE PRINT)

Date:________________

Name:____

Last Name First Name Middle Initial

Mailing Address:____

City:____________________State:__________Zip:______________

Home Phone:____________________Cell:____________________

Social Security #:____________Birthdate:__________Sex:Male/Female

Single ☐ Married ☐ Divorced ☐ Widowed ☐

Employer Name:______________________Work Phone:____________

Who should be notified in an emergency?__________________________

Relationship to Patient?________________Phone#:_______________

Responsible Party Information

Who is responsible for this account?______________________________

Relationship to Patient?__________Responsible PartySS#:____________

Insurance Information

Do you have medical insurance? Yes / No

Name of Primary Insurance:___________________________________

Member ID#:__________________Group#:______________________

Name of Secondary Insurance:_________________________________

Member ID#:__________________Group#______________________

Referral Information

How did you learn of our practice?_______________________________

Whom may we thank for referring you?____________________________

Please list other doctors you have seen in the past five years:____________

____

We need for you to show us your current insurance card(s) and sign/date below **once a month** to verify that all information is correct. Thank you!

sign/date:____________________**sign/date:**____________________

sign/date:____________________**sign/date:**____________________

sign/date:____________________**sign/date:**____________________

sign/date:____________________**sign/date:**____________________

sign/date:____________________**sign/date:**____________________

sign/date:____________________**sign/date:**____________________

Tariq Javed, MD, Inc, 515 S Locust St, Visalia, CA 93277
Ph: (559) 625-8674 Fax: (559) 625-4699
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390 Pearson Dr, Porterville, CA 93257
Ph: (559) 793-4400 Fax: (559) 793-4500

CONSENT/AUTHORIZATION FORM

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Date______ ____________

CONSENT FOR TREATMENT I authorize the above-named doctor(s), to perform the treatment/ procedure(s) described below. I have been informed of the reasons for the treatment/procedure(s), along with the expected benefits, risks, possible alternative methods of treatment, and possible consequences involved in the following:

____

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____

The treatment/procedure(s) was explained to me in detail and all my questions were fully answered. Understanding this, I authorize the above-named doctor(s) to perform such examinations, treatments, laboratory tests, and to administer such medications as, in his or her opinion, are necessary or advisable for me (or ________________________________).
Name of patient if minor

I also certify that no guarantee or assurance has been made as to the results that may be obtained.

RELEASE OF MEDICAL RECORD In order to ensure proper follow-up and continuity of care, I agree that a copy of my medical record may be released to my physician, a designated referral physician, and/or the provider, if any, who referred me here.

INSURANCE AUTHORIZATION I request that payment of authorized benefits be made to the above-named doctor(s) on my behalf, for any services provided to me. I authorize any holder of medical and other information about me to release to Medicare and its agents, any insurance company, any other third party payer, state medical assistance agency, or any other governmental or private payer responsible for paying such benefits, any information needed to determine these benefits or benefits for related services. I agree to pay for all charges not covered by a third party payer. I authorize a copy of this authorization to be used in place of the original.

Signed Date

Renal Medical Group Policy

To our Valued Patient:

This is an explanatory letter regarding Renal Medical Group's policies effective January 1, 2002.

Appointments:

Appointments will be made at the front desk and you will be given an appointment card. We will not necessarily call to remind you of the appointment. That is something we do as a courtesy for our patients. If you can not make it on your scheduled time or date we require a 24 hour notice of cancellation. There is a possibility we will charge you for the visit if you do not show up.

Insurance Information:

It is the patient's responsibility to inform us of any insurance changes before the appointment date. If we do not have the correct information, we can not bill the correct insurance. We will bill your insurance one time and if the charge is denied for any reason other that a mistake on our part, you will be responsible for the balance owed (this includes any kind of injection). We need to see your insurance card(s) every time you come in for an appointment (excluding patients who come in weekly). If you receive a statement from our office with a balance owing, that balance must be paid before your next appointment.

CO-Payments:

Your co-payment must be paid before you leave the office. If you have secondary insurance and your primary insurance requires a co-payment, you are still responsible to pay the co-payment.

Pre-Visit Forms:

Every patient is required to fill out a pre-visit form before seeing the doctor. If you are not able to fill the form out, you need to bring someone with you to the appointment that can fill it out for you.

Forms:

The patient's portion of any type of form, brought in for doctor signature or to be filled out, must be completely filled in. We DO NOT sign blank forms!

Messages:

If you leave a message for the doctor with someone in the office, it will be dealt with before 5:30pm the same day unless you are told otherwise. DO NOT call throughout the day to see if we have an answer yet. We will call you when we do.

Patient Signature and Date: ______________________________

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Renal Medical Group Medical History Form

Date ____________________

I am here for: ____

____

Please take a few minutes while waiting to provide additional information about you or your relative's Medical History. Knowledge of past medical problems, family medical problems, and personal health habits will help the doctor provide better care. Please complete this to the best of your ability.

Section 1: Past Medical History

Shade circle of all that apply or 'None of these' if you have not experienced any of the listed disorders.

- O None of these
- Diabetes: O Insulin O Pills O Diet
- O High Blood Pressure
- O Heart Disease
- O Emphysema
- O Asthma
- O Stroke
- O Black-outs
- O Seizure Disorder
- O Thyroid Disease
- O Migraine
- O Arthritis
- O Cancer
- O Blood Disease
- O Kidney Disease
- O Psychiatric Disease
- Hepatitis O A O B O C O unknown
- O Gout
- O Abnormal Bleeding or Clotting
- O Alcohol or Drug Dependence
- O Other ____________

Section 2: Past Surgeries

Shade circle of all that apply or 'None of these' if you have not experienced any of the listed surgeries.

- O None of these
- O Tonsils & Adenoids
- O Appendix
- O Gallbladder
- O C-Section
- O Hernia
- O Hysterectomy O Ovaries Removed
- O Colon
- O Breast
- O Lung
- O Biopsy of ____________
- O Back
- O Neck
- O Coronary Artery Bypass
- O Angioplasty
- O Prostate
- O Stomach
- O Carotid Artery
- O Thyroid
- O Brain
- O Shoulder
- O Hip
- O Knee
- O Leg
- O Ankle
- O Cataract
- O Other ____________

Section 3: Family History

Shade circle of all that apply or 'None of these' if your family does not have a history of any of the following.

- O None of these
- O Diabetes
- O Heart Disease
- O Strokes
- O Cancer
- O Alcohol or Drug Dependence
- O Bleeding or Clotting Disorder
- O Any Rare or Unusual Disease
- O Any Disease That 'Runs in the Family'

Information on Patient's Father:

Age Now or Age When Died [|] O Exact O About

Status: O Alive O Died O Unknown

If Dead, How?

- O Heart Problem
- O Stroke
- O Cancer
- O Accident
- O Infection
- O Old Age
- O Unknown
- O Other ________

Information on Patient's Mother:

Age Now or Age When Died [|] O Exact O About

Status: O Alive O Died O Unknown

If Dead, How?

- O Heart Problem
- O Stroke
- O Cancer
- O Accident
- O Infection
- O Old Age
- O Unknown
- O Other ________

Name: ______________________________

Section 4: Social History

Marital Status	Children/Friends Nearby to Help with Convalescence?	Living Status	Occupation	Type of Work
○ Married ○ Single ○ Widowed ○ Divorced ○ Separated	○ No ○ Yes	○ Alone ○ With Family or Roommate ○ Board & Care ○ Nursing Home	○ Working ○ Unemployed ○ Retired ○ Disabled	○ Office Job ○ Physical Labor ○ Homemaker

Cigarettes (Packs Per Day	I Quit Smoking	Caffeine (Cups of Coffee or Tea Per Day)	Alcohol	Drugs
○ Do Not Smoke ○ Less Than 1 ○ 1 ○ 1-2 ○ 2 ○ More Than 2	○ I Never Smoked ○ < 1 Month Ago ○ < 1 Year Ago ○ Over 1 Year Ago ○ Over 6 Years Ago ○ Over 10 Years Ago	○ None ○ 2 or Less ○ 2-5 ○ 5-10	○ None ○ Rarely ○ Occasionally ○ Regularly ○ Daily	○ None ○ Amphetamines ○ Cocaine ○ Heroin ○ Marijuana ○ Hallucinogens

Section 5: Review of Systems

Shade an answer in all categories

Constitutional
- ○ None of these
- ○ Regular Fevers or Chills
- ○ Weight Loss
- ○ Weight Gain
- ○ Loss of Appetite

Eyes
- ○ None of these
- ○ Wear Contacts
- ○ Wear Glasses
- ○ Eye Surgery
- ○ Cataracts
- ○ Trouble Seeing

Ears, Nose, Throat
- ○ None of these
- ○ Frequent Ear Infections
- ○ Ear Surgery
- ○ Hearing Problems
- ○ Hayfever
- ○ Sinus Surgery
- ○ Frequent Nose Bleeds
- ○ Persistent Hoarseness
- ○ Trouble Swallowing

Respiratory
- ○ None of these
- ○ Asthma
- ○ Emphysema
- ○ Wheezing
- ○ Pain With Breathing
- ○ Long Lasting Cough

Allergy - Immunology
- ○ None of these
- ○ Food Allergy
- ○ Drug Allergy
- ○ Immune System Disorder

Cardiovascular
- ○ None of these
- ○ Shortness of Breath on Exertion
- ○ Shortness of Breath at Night
- ○ Angina
- ○ Chest Pains
- ○ Heart Attack
- ○ Heart Surgery
- ○ Pacemaker
- ○ Leg Swelling

Gastrointestinal
- ○ None of these
- ○ Nausea
- ○ Vomiting
- ○ Diarrhea
- ○ Constipation
- ○ Vomiting Blood
- ○ Blood in BM
- ○ Black Tar-like BM
- ○ Jaundice
- ○ Hepatitis
- ○ Ulcer
- ○ Hiatal Hernia
- ○ Change in BM Habits

Integumentary
- ○ None of these
- ○ Hives
- ○ Cancer of Skin
- ○ Change in Size or Color of Mole
- ○ Psoriasis
- ○ Other Skin Disorder

Hematology - Lymphatics
- ○ None of these
- ○ Bleeding Problems
- ○ Blood Clots
- ○ Swollen Glands
- ○ Cancer of Blood or Lymph Gland

Name ______________________________

Section 5: Review of Systems (Cont.):

Neurological
- ○ None of these
- ○ Migraine
- ○ Other Headaches
- ○ Frequent Dizzy Spells
- ○ Poor Balance
- ○ Black Outs
- ○ Seizure Disorder
- ○ Stroke
- ○ New Numbness or Tingling
- ○ New Weakness
- ○ Brain or Nerve Disease
- ○ Evaluation by Neurologist
- ○ CAT Scan or MRI

Psychiatric
- ○ None of these
- ○ Nervousness
- ○ Panic Disorder
- ○ Depression
- ○ Bipolar (Manic-Depressive)
- ○ Schizophrenia

Cancer
- ○ None of these
- ○ Colon
- ○ Breast
- ○ Lung
- ○ Prostate
- ○ Skin
- ○ Thyroid
- ○ Throat
- ○ Stomach
- ○ Brain
- ○ Bone
- ○ Muscles
- ○ Uterus
- ○ Ovaries
- ○ Kidney
- ○ Other

Genitourinary
- ○ None of these
- ○ Pain on Urination
- ○ Frequent Urination
- ○ Blood in Urine
- ○ Change in Stream of Urine
- ○ Prostate Problems
  - ○ Untreated ○ Surgery ○ Medicines
- ○ Up at Night to Urinate
  - ○ 1 ○ 2 ○ <5 ○ >5 Times
- ○ Kidney Stones
- ○ Kidney Surgery
- ○ Kidney Failure
- ○ Penile or Vaginal Discharge

Musculoskeletal
- ○ None of these
- ○ Rhuematoid Arthritis
- ○ Other Arthritis
- ○ Gout
- ○ Bursitis Shoulder
- ○ Bursitis Hip
- ○ Sciatica
- ○ Frequent Back Pains
- ○ Back Surgery
- ○ Frequent Neck Pain
- ○ Neck Surgery
- ○ Previous Fractured Bones
- ○ Hip Surgery
- ○ Knee Surgery

Endocrine
- ○ None of these
- ○ Thyroid Disease
- ○ Diabetes
- ○ Craving Water
- ○ Frequent Urination
- ○ New Heat Intolerance
- ○ New Cold Intolerance
- ○ Recent Weight Loss
- ○ Recent Weight Gain

OB-GYN ○ Male - Not Applicable
- ○ None of these
  - Number of Pregnancies ☐
  - Number of Live Births ☐
  - Number of Abortions ☐
  - Number of Miscarriages ☐
  - Number of C-Sections ☐
- ○ Hysterectomy
  - ○ Ovaries Removed
- ○ Abnormal Vaginal Bleeding
- ○ Abnormal Discharge
- ○ Cysts on Ovaries
- ○ Painful Intercourse
- ○ Endometriosis
- ○ Other Operations

STD - Sexually Transmitted Disease
- ○ None of these
- ○ Syphilis
- ○ Gonorrhea
- ○ Genital Herpes
- ○ Chlamydia
- ○ Trichomonas
- ○ AIDS
- ○ Penile Discharge
- ○ Sores or Growths on Genitals
- ○ Other

Section 6: Current Medications

Write the name, strength, and dosage schedule of the medications you are currently taking.

______________________ ______________________ ______________________

______________________ ______________________ ______________________

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Name: ______________________