UNIVERSITY NEPHROLOGY

1932 ALCOA HIGHWAY, SUITE 460
KNOXVILLE, TN 37920-1511
Phone (865) 546-9246 Fax (865)523-6466

URATH SURESH, MD - ROSS NESBIT, MD - RITU KHANNA, MD
KAITLIN GREEN, FNP-BC – ANDREW BROWER, FNP-BC – KACI NEWLIN, FNP-BC

PATIENT INFORMATION

DATE_____

NAME_____ DATE OF BIRTH____/____/____. AGE _____ SEX M / F
(LAST) (FIRST) (M.I.)

ADDRESS_____ APT/UNIT_____

CITY_____ STATE_____ ZIP CODE_____

HOME PHONE (____) _____ EMPLOYER_____

ALTERNATE (____) _____ ADDRESS_____

CELL PHONE (____) _____ WORK PHONE (____) _____

SS#_____ EMAIL_____

MARITAL STATUS: Single / Married / Widowed / Divorced / Separated **LIVING ARRANGEMENT:** with – Spouse / Independently / Caregiver or Family

RACE: White / Black / Native American / Asian / Native Hawaiian / Other **PRIMARY LANGUAGE**: English / Spanish / Italian / Hindi / Other

ETHNICITY: Non-Hispanic or Non-Latino / Hispanic or Latino

SPOUSE_____ DATE OF BIRTH____/____/____.

ADDRESS_____ HOME PHONE (____)_____

EMPLOYER_____ WORK PHONE (____)_____

ADDRESS_____ CELL PHONE (____)_____

EMERGENCY CONTACT_____ RELATIONSHIP_____

ADDRESS_____ HOME PHONE (____) _____

WORK PHONE (____) _____ CELL PHONE (____) _____

REFERRING PHYSICIAN _____ PHONE (____) _____

ADDRESS_____ FAX # (____) _____

OTHER PHYSICIANS _____ PHONE (____) _____

_____ PHONE (____) _____

_____ PHONE (____) _____

PHARMACY (including address) _____ PHONE (____) _____

_____

PRIMARY INSURANCE

INSURANCE CO. NAME _____ PHONE (____) _____

ID # _____ GROUP # _____

SECONDARY INSURANCE

INSURANCE CO. NAME _____ PHONE (____) _____

ID # _____ GROUP # _____

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PATIENT'S NAME: _____ DATE OF BIRTH: _____

1. May we leave confidential messages with anyone answering the telephone on your home/cell number?
   ☐ Yes ☐ No
2. May we leave confidential messages regarding appointments, return calls for test results, etc. on your home/cell voicemail?
   ☐ Yes ☐ No
3. May we leave confidential messages with anyone answering the telephone regarding appointments, lab results or other healthcare information at numbers other than your home phone number? ☐ Yes ☐ No

   If yes, please list numbers: (_____)_____; (_____)_____
4. If we are unable to reach you by any of the above options, may we leave confidential messages at your place of employment?
   ☐ Yes ☐ No
5. **ONLY** release information to those I list (Please give full names):

   Name: _____ Relationship: _____ Phone: _____

   Name: _____ Relationship: _____ Phone: _____
6. Check this box only if you **DO NOT** want any information released to anyone, including your spouse and/or other household members. ☐

If we are unable to reach you by any other means, we will send information through the U.S. Postal Services to your home address.

I acknowledge I have received a copy of the Notice of Privacy Practices and have been given the opportunity to read it, have it explained to me, and ask questions. I understand that this Notice describes how my health information may be used or disclosed by University Nephrology of Knoxville and its physicians and other providers and that I should read it carefully. I am aware that the Notice may be changed at any time, and I may obtain a revised copy of the Notice by contacting the office.

_____ _____
Signature of Patient Date

RELEASE AUTHORIZATION/ASSIGNMENT

I request that payment of the authorized insurance benefits be made on by behalf to UNIVERSITY NEPHROLOGY OF KNOXVILLE for any services furnished to me by that provider. I authorize any holder of medical information about me to release to the HEALTH CARE FINANCING ADMINISTRATION and its agents any information needed to determine these benefits or the benefits payable for the related services.

I authorize the billing of my Medigap insurers, if applicable, on my behalf and request payment to UNIVERSITY NEPHROLOGY OF KNOXVILLE for any services furnished to me by that provider.

I authorize any physician examining and/or treating me to release to any third party (such as an insurance company or government agency) any medical information requested for use in determining claim for payment. I also request payment benefit to UNIVERSITY NEPHROLOGY OF KNOXVILLE.

_____ _____
Signature of Patient Date

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NAME: _____ **REFERRING DOCTOR:** _____

PRESENT HEALTH CONCERNS RELATING TO VISIT TODAY: _____

_____

ALLERGIES TO MEDICATIONS (Please indicate if None Known):

MEDICATION	REACTION OR SIDE EFFECT

MEDICATIONS:

MEDICATION	DOSE	TIMES PER DAY

MEDICATION	DOSE	TIMES PER DAY

PERSONAL MEDICAL HISTORY:

Please indicate whether you have/have had any of the following medical problems (with approximate date of illness or diagnosis):

_____Vision Problems
_____Blindness
_____Cataracts
_____Hearing problems
_____High Blood Pressure
_____Heart Attack/MI
_____Irregular Heartbeat
_____Pacemaker/Defibrillator
_____Congestive Heart Failure
_____COPD/Emphysema
_____Pneumonia
_____Tuberculosis
_____Asthma
_____Heartburn/Gastric Reflux
_____Stomach Ulcers
_____Bowel Disease
_____Gall Bladder Disease
_____Hepatitis
_____Frequent Urinary Tract Infections
_____Problems Urinating
_____Prostate Problems
_____Kidney Stones
_____Stroke
_____Seizures
_____Paralysis/Weakness
_____Thyroid Problems
_____Diabetes
_____Arthritis
_____Gout
_____Anemia
_____Lupus
_____Depression
_____HIV
_____Cancer (Type): _____

SURGICAL HISTORY (Please list all prior operations and dates):

OPERATION	DATE

OPERATION	DATE

IMMUNIZATIONS: Pleas list most recent immunizations and dates

_____ Hepatitis A
_____ Hepatitis B
_____ Tetanus (Td)
_____ Measles
_____ MMR
_____Varicella (chicken pox)
_____ Pneumovax (Pneumonia)
_____ Influenza (FLU)
_____ Shingles
_____ Mumps
_____ Rubella
_____ Other

SOCIAL HISTORY

_____Right Handed _____Left Handed
Highest Education Level Completed: _____Grade School
_____High School _____GED _____College _____Graduate School

Occupation_____
Previous types of jobs held_____
_____

Tobacco Use:

Cigarettes:
Never
Quit Date: _____
Current Smoker: _____packs/day _____# of yrs
Other Tobacco: Pipe / Cigar / Snuff / Chew

Alcohol Use:

Do you drink alcohol? No / Yes: _____ # drinks/week
Have you ever had Toxic Exposures (fumes, chemicals, etc)?
_____No _____Yes: _____
Illicit Drug Use: Currently / Quit / Never
What are some of your stress issues?
_____

FAMILY HISTORY

Please indicate family members who have had any of the following:

Medical Cond.	Mom	Dad	Sis	Bro	Daug	Son	Other
Alcoholism							
Anemia							
Anesthesia Prob							
Asthma							
Birth Defects							
Bleeding Prob							
Cancer, Breast							
Cancer, Colon							
Cancer, Skin							
Cancer, Ovary							
Cancer, Prostate							
Cancer, Other							
Depression							

Medical Cond.	Mom	Dad	Sis	Bro	Daug	Son	Other
Hay Fever							
Hearing Prob							
Heart Attack							
High Blood Pressure							
High Cholesterol							
Kidney Disease							
Lupus							
Mental Retardation							
Migraines							
Mitral Valve Prolapse							
Osteoarthritis							
Osteoporosis							
Rheumatoid Arthritis							
Seizures							
Stroke							
Thyroid Disorders							
Tuberculosis							
Other:							

If deceased, please provide **AGE** and **CAUSE OF DEATH**

Mother: _____
Father: _____
Siblings: _____
Children: _____