NANI
Nephrology Associates of Northern Illinois and Indiana

# PATIENT DEMOGRAPHIC AND INSURANCE INFORMATION

**Patient's Name (First, Middle, Last):** _____

**Address:** _____

**Social Security #:** _____ **Date of Birth:** _____ **Sex:** [ ] M [ ] F

**Marital Status:** [ ] Single [ ] Married [ ] Divorced [ ] Widowed

**Race:** [ ] American Indian or Alaskan Native
[ ] Asian
[ ] Black or African American
[ ] Native Hawaiian
[ ] White/Caucasian
[ ] Other: _____

**Preferred Language:** [ ] English [ ] Spanish [ ] French
[ ] German [ ] Chinese
[ ] Other: _____

**Ethnicity:** [ ] Hispanic or Latino
[ ] Not Hispanic or Latino

**Preferred Contact Method:** [ ] Home Phone [ ] Cell Phone [ ] Email [ ] Other: _____

**Home Phone #:** ( ) _____ **May we leave a message?** [ ] Y [ ] N
**Work Phone #:** ( ) _____ **May we leave a message?** [ ] Y [ ] N
**Cell Phone #:** ( ) _____ **May we leave a message?** [ ] Y [ ] N
**Email Address:** _____

**Emergency Contact Information:**

**Name:** _____ **Phone #:** _____
**Relationship to Patient:** [ ] Self [ ] Spouse [ ] Parent [ ] Other: _____

**PRIMARY CARE PHYSICIAN INFORMATION**

**Name:** _____ **Phone #:** _____
**Office Address:** _____ **Affiliated Medical Group (i.e. DMG):** _____

**REFERRING PHYSICIAN'S INFORMATION** **[ ] Check here if referring is same as the PCP listed above**

**Name:** _____ **Phone #:** _____
**Office Address:** _____ **Affiliated Medical Group (i.e. DMG):** _____

**PRIMARY INSURANCE INFORMATION**

**Insurance Carrier:** _____ **Policy #:** _____ **Group #:** _____
**Insured/Policy Holder Information** **Relation to Patient:** [ ]Self [ ]Spouse [ ]Parent [ ]Other: _____
**Name:** _____ **Date of Birth:** _____
**Address:** _____

**SECONDARY INSURANCE INFORMATION**

**Insurance Carrier:** _____ **Policy #:** _____ **Group #:** _____
**Insured/Policy Holder Information** **Relation to Patient:** [ ]Self [ ]Spouse [ ]Parent [ ] Other: _____
**Name:** _____ **Date of Birth:** _____
**Address:** _____

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# MEDICAL HISTORY

**Patient's Name:** _____ **Date of Birth:** _____

## MEDICAL DISEASES AND PROBLEMS

*Please list any diseases or medical problems you currently have or have had in the past. For each diagnosis, please specify date of onset, date of resolution, and previous/current treatments, if known.*

| Disease/Problem | Dates (Onset/Resolution) (*If known*) | Current/Previous Treatments (*i.e. Medications, Procedures*) |
|---|---|---|
| **1.** | **Onset:** **Resolution:** | |
| **2.** | **Onset:** **Resolution:** | |
| **3.** | **Onset:** **Resolution:** | |
| **4.** | **Onset:** **Resolution:** | |
| **5.** | **Onset:** **Resolution:** | |

**Please include a separate sheet listing any additional medical diseases/problems to be included in your medical chart that you could not fit in the grid above.**

## SURGICAL HISTORY

*Please list any surgeries and procedures you have had in the past as well as any that are scheduled to be performed in the future. For each, please specify date (if only year is known, please indicate), where it was performed, and by whom, if known.*

| Surgery/Procedure | Date (if known) | Performed By | Location |
|---|---|---|---|
| **1.** | | | |
| **2.** | | | |
| **3.** | | | |
| **4.** | | | |
| **5.** | | | |

**Please include a separate sheet listing any additional surgeries/procedures to be included in your medical chart that you could not fit in the grid above.**

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## MEDICAL HISTORY (continued)

**Patient's Name:** _____ **Date of Birth:** _____

**FAMILY HISTORY**

*Please indicate which of the following diseases, if any, have affected any members of your family and specifically whom. Please also include any additional diseases not listed in the section provided.*

| | Relative(s) Affected | | Relative(s) Affected |
|---|---|---|---|
| **Heart Disease** [ ] | | **High Blood Pressure** [ ] | |
| **Diabetes** [ ] | | **Lung Disease** [ ] | |
| **Stroke** [ ] | | **Gastrointestinal Disease** [ ] | |
| **Cancer** [ ] | | **Neurological Disease** [ ] | |
| **Liver Disease** [ ] | | **Arthritis** [ ] | |
| **Kidney Disease** [ ] | | **Vein or Artery Disease** [ ] | |

**SOCIAL HISTORY**

1. **Indicate your current smoking status:** [ ] Current smoker [ ] Former smoker [ ] Never smoker
2. **Do you drink alcohol?** [ ] Yes [ ] No
   **If Yes:** How often do you drink: [ ] Daily [ ] Occasionally [ ] Rarely (few times/year)
   How many drinks per day? _____ What do you drink?
   How long have you been drinking?
3. **Do you use any caffeinated products?** [ ] Yes [ ] No
   **If Yes:** What products do you use? [ ] Coffee [ ] Tea [ ] Soda [ ] Chocolate [ ] Energy Drinks
   How much do you use per day?

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# CURRENT MEDICATIONS

**Patient's Name:** _____ **Date of Birth:** _____

*Please provide a complete list of the medications you are currently taking including any prescription, herbal, over the counter, and vitamin/supplements. You may either write them below or provide a photocopy of your current list. Please include medication name, dose, how you take it (i.e. by mouth), and frequency.*

| Medication Name | Dose/Strength | Route (i.e. by mouth) | Frequency (times per day) |
|---|---|---|---|
| 1. | | | |
| 2. | | | |
| 3. | | | |
| 4. | | | |
| 5. | | | |
| 6. | | | |
| 7. | | | |
| 8. | | | |
| 9. | | | |
| 10. | | | |

**Please include a separate sheet listing any additional medications that you are taking that you could not fit in the grid above.**

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# CURRENT ALLERGIES, IMMUNIZATIONS, AND PHARMACY INFORMATION

**Patient's Name:** _____ **Date of Birth:** _____

## ALLERGIES

**Do you have any allergies?** [ ] Yes [ ] No

**If Yes,** please list your allergies (medication, food, latex, dyes, environment, etc.) and associated reactions.

| Allergy | Reaction |
|---|---|
| 1. | |
| 2. | |
| 3. | |
| 4. | |
| 5. | |

## IMMUNIZATION STATUS

1. **Pneumonia (Pneumococcal), date last vaccinated (Month/Date/Year, if known):** _____
   **By Whom (i.e. Primary Doctor)?** _____

2. **Flu (Influenza), date last vaccinated (Month/Date/Year, if known):** _____
   **By Whom (i.e. Primary Doctor)?** _____

## PREFERRED PHARMACIES FOR PRESCRIPTION MEDICATIONS

**Preference #1**

**Pharmacy Name**: _____ **Mail order pharmacy?** [ ] Yes [ ] No
**Address:** _____
**Phone #**: (  ) _____ **Fax #:** (  ) _____

**Preference #2**

**Pharmacy Name**: _____ **Mail order pharmacy?** [ ] Yes [ ] No
**Address:** _____
**Phone #**: (  ) _____ **Fax #:** (  ) _____