REGISTRATION FORM

(Please Print)

PCP: Phone Number: Hospital:

PATIENT INFORMATION

Patient's Last Name: First: Middle Initial:	☐ Mr. ☐ Mrs.	☐ Miss ☐ Ms.	Marital Status (circle one): Single / Married / Div /Sep / Wid

Is this your legal name? ☐ Yes ☐ No	If not, what is your legal name? (Former Name):	Birthdate: / / Age:	Sex: ☐ M ☐ F

Street Address:	Social Security Number:	Home/Cell Phone Number(s): ( ) ( )

P.O. Box:	City: State:	Zip Code:

Occupation:	Employer:	Employer Phone Number: ( )

Referred to clinic by (please check one box): ☐ Dr. _____ ☐ Insurance Plan ☐ Hospital
☐ Family ☐ Friend ☐ Close to home/work ☐ Yellow Pages ☐ Other

Email address:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Responsible Party:	Birth date: / /	Address (if different from above):	Home Phone Number: ( )

Is this person a patient here?: ☐ Yes ☐ No

Occupation:	Employer:	Employer Address:	Employer Phone Number: ( )

Is this patient covered by insurance?: ☐ Yes ☐ No

Please indicate primary insurance: ☐ Insurance: _____ ☐ Insurance: _____ ☐ Insurance: _____
☐ Insurance: _____ ☐ Welfare (Please provide coupon): _____ ☐ Other: _____

Subscriber:	Subscriber Social Security:	Birth Date: / /	Policy Number:	Group Number:	Co-payment: $

Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

Name of secondary insurance (if applicable): Subscriber Name: Policy Number: Group Number:

Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

IN CASE OF EMERGENCY

Emergency Contact:	Relationship to patient:	Home Phone Number: ( )	Work Phone Number: ( )

I agree that the information supplied on this from is accurate and up to date to the best of my knowledge. I hereby authorize Kidney Specialists of The Woodlands and Conroe, Michael J. Walls, M.D.to release any information acquired in the course of my examination and treatment for insurance purposes. I hereby authorize any payment of medical benefits to be paid directly to the above name physician for their services. I understand that I am financially responsible for any charge not covered by insurance and this authorization. A fax copy of this authorization may be exhibited as proof of my consent.

Patient/Guardian Signature: **Date:**

4015 Interstate 45 North, Ste. 310 Conroe, TX 77304
4185 Technology Forest Blvd, Ste 210 The Woodlands, TX 77381
Office: (936) 520-8983 • Fax: 1-(936) 463-6508

MEDICATION FLOWSHEET

Patient Name and Date of Birth:	Allergies:

	MEDICATION				
	Dosage/Direction/Amount				

Signature: _____ Date: _____/_____/_____

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Name: _____ Date of Birth: _____/_____/_____

PAST/CURRENT PERSONAL MEDICAL HISTORY: Have YOU EVER had any of the following?

Heart/Lungs:
- ☐ Asthma
- ☐ Heart Disease (valve, vessel, rheumatic, etc.)
- ☐ Heart Murmur
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Pneumonia

Endocrine:
- ☐ Adrenal Disorders
- ☐ Diabetes
- ☐ Polycystic Ovary Syndrome (PCOS)
- ☐ Thyroid Disorder

Kidney:
- ☐ Chronic Kidney infections or Bladder Disease
- ☐ Kidney Stones

Ears/Eyes/Nose/Throat:
- ☐ Chronic Sinus Infections
- ☐ Eye Disorders (other than glasses or contacts)
- ☐ Hearing Loss
- ☐ Nasal Allergies or Hayfever

☐ **NO Significant Health Problems**

Stomach/Bowel:
- ☐ Celiac Disease
- ☐ Irritable Bowel Syndrome
- ☐ Stomach/Duodenal Ulcers
- ☐ Ulcerative Colitis/Crohn's
- ☐ Other Liver, Stomach, or Bowel Disease

Neurological:
- ☐ Concussions
- ☐ Convulsions/Seizures
- ☐ Migraines/Severe Headaches
- ☐ Multiple Sclerosis
- ☐ Muscular Dystrophy
- ☐ Stroke/TIA

Mental Health:
- ☐ ADHD
- ☐ Alcohol Abuse
- ☐ Anorexia (Eating Disorder)
- ☐ Anxiety Disorder
- ☐ Bulimia (Eating Disorder)
- ☐ Depression
- ☐ Drug Dependency
- ☐ Other Mental Health _____

Hematology:
- ☐ Anemia
- ☐ Bleeding Disorders
- ☐ Blood Clots/Clotting Disorders
- ☐ Cancer
- ☐ Radiation Therapy

Orthopedics:
- ☐ Arthritis
- ☐ Fractures/Broken Bones

Infectious Disease:
- ☐ Chickenpox/Varicella
- ☐ Hepatitis Type: ____
- ☐ HIV Infection
- ☐ Infectious Mononucleosis
- ☐ Malaria
- ☐ Mumps
- ☐ Tuberculosis
- ☐ Typhoid Fever

Skin:
- ☐ Eczema
- ☐ Psoriasis
- ☐ Hives

STD's:
- ☐ Chlamydia
- ☐ Genital Herpes
- ☐ Genital Warts
- ☐ Gonorrhea
- ☐ HPV
- ☐ Other STD's

Surgical History:
- ☐ Appendectomy
- ☐ Adenoidectomy
- ☐ Tubes in Ears
- ☐ Gallbladder Removal
- ☐ Knee ACL Repair L_____ R_____
- ☐ Knee Arthroscopy L_____ R_____
- ☐ Organ Transplant
- ☐ Ovarian Cyst Removal
- ☐ Splenectomy
- ☐ Tonsillectomy
- ☐ Weight Loss Surgery
- ☐ Other Prior Surgeries _____

Social History:
- ☐ Do you drink alcohol
- ☐ Do you exercise regularly?
- ☐ Do you take recreational

OB/GYN History:
- ☐ Endometriosis
- ☐ Pregnancies #: _____

Exercise History:
- ☐ Lack of exercise
- ☐ Exercising regularly

Moderate exercising: walking briskly, water aerobics, etc.
- ☐ Less than 3 times per week
- ☐ 3 or more times per week

Strenuous exercising: running, swimming laps, etc.
- ☐ Less than 3 times per week
- ☐ 3 or more times per week

Be prepared to inform the nurse of current medications (include birth control, acne, over the counter medications, vitamins, etc.

Allergies:

Have you ever had an allergic reaction? ☐ Yes ☐ No
Medication allergies: _____
Food allergies: _____
Other allergies (latex, beestings, etc.):

Order History:

☐ Previous Hospitalizations: _____ ☐ Other Health Problems: _____

Does YOUR IMMEDIATE FAMILY have any of the following? ☐ **Adopted (Family history unknown)**

	Mother	Father	Siblings	Grandparents
Alcoholism				
Blood Clots/Clotting Disorders				
CANCER: Breast				
CANCER: Colon				
CANCER: Melanoma				
CANCER: Other Cancers (List Type)				
Diabetes				
Drug Dependency				
Heart Disease				
High Blood Pressure				
High Cholesterol				
Mental Illness				
Stroke				
Sudden Cardiac Arrest (under age 50)				
Other (please explain):				
Parents Deceased				

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Patient Name: _____ Date of Birth: ____/____/____

Assignment of Benefits and Release of Patient Healthcare Information

I hereby authorize KIDNEY SPECIALISTS OF THE WOODLANDS AND CONROE, Michael J. Walls, M.D. to release patient healthcare information, compiled from the medical records pertaining to my services, in accordance with the police of the clinic and Texas law, to facilitate reimbursement by a health benefit plan or third party payer, including but not limited to, my insurance carrier, Medicare, Medicaid, and any other payer or agency. I also hereby authorize payment of insurance benefits under the terms of my police directly to KIDNEY SPECIALISTS OF THE WOODLANDS AND CONROE, Michael J. Walls, M.D. for services rendered. I am financially responsible and will pay for charges not covered by my insurance plan.

Financial Agreement and Statement of Responsibility

For and in consideration of services rendered or to be rendered by KIDNEY SPECIALISTS OF THE WOODLANDS AND CONROE, Michael J. Walls, M.D., I agree to pay said clinic for all services and charges. I understand that I am responsible for any health insurance deductibles, coinsurance, and non-covered charges. Payment in full is due at time services are rendered or payment arrangements are to be made before your appointment.

Consent to Medical Treatment by Physician

I, or authorized representative/legal guardian acting on behalf of the patient, do hereby consent to receiving general medical services, which may include routine diagnostic procedures and such medical treatment as the physician, his/her assistants or his/her designees consider to be necessary in his/her judgment. I also acknowledge that the practice of medicine is not an exact science and that no guarantees have been made to me as to results of treatment or examination at KIDNEY SPECIALISTS OF THE WOODLANDS AND CONROE, Michael J. Walls, M.D.

Consent to Medical Treatment by a Physician Assistant

I, or authorized representative/legal guardian acting on behalf of the patient, do hereby consent to receiving general services from a physician assistant. I fully understand that a physician assistant IS NOT A PHYSICIAN. I further acknowledge that the general medical services provided to me by a physician assistant are the responsibility of the physician providing the services at KIDNEY SPECIALISTS OF THE WOODLANDS AND CONROE, Michael J. Walls, M.D. both professionally and legally, for acts of such allied health personnel rendered during the care and treatment of his/her patients.

Release of Patient Healthcare Information

I hereby authorize KIDNEY SPECIALISTS OF THE WOODLANDS AND CONROE, Michael J. Walls, M.D. to release patient healthcare information, in accordance with the policy of the clinic, as is necessary to health care providers to facilitate reimbursement by health benefit plan or personnel of another health care entity for the sole purpose of providing current continuum of care including, but not limited to fax, mail or electronic submission.

Patient/Guarantor Signature: _____ Date: _____

Do you have an advanced directive (living will)? _____ Yes _____ No

If yes, please bring a copy into our office for our files.

If no, and you would like information on an advanced directive, please speak with your physician.

The above authorizations are valid unless you specify otherwise or revoke them in writing.

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PATIENT RECORD OF DISCLOSURES

I, _____, give my authorization to release
My protected health information including results of my laboratory test, x-ray and/or other test results to the following designated representative(s):

My Spouse (Name/Number)_____

My Child (Name/Number)_____

Other (Name/Number)_____

____ MAY NOT BE GIVEN TO ANYONE OTHER THAN MYSELF

I wish to be contacted in the following manner (check ALL that apply)

Home and/or Cell Telephone # _____ Written Communication

[ ] O.K. to leave message with detailed information [ ] O.K. to mail to my home address

[ ] Leave message with call-back number only [ ] O.K. to mail to my work/office

Patient Signature _____ Date _____

Definition: Sexually Transmitted Disease (STD) as defined by laws, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

☐ Yes ☐ No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, To the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

☐ Yes ☐ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature _____ Date _____

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

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

I request and authorize use or disclosure of protected health information about me as described below.

The following specific person or class of persons or facility is authorized to make the requested use or disclosure:

Records From: _____
_____
_____

The following person or class of persons may receive disclosure of protected health information about me:

Records To: Kidney Specialists of The Woodlands and Conroe, Michael J. Walls, M.D.
4015 IH 45 North, Ste. 310
Conroe, Texas 77304 Ofc: (936) 520-8983; Fax:1 (936) 463-6508

Specific description of information to be released (include dates of service):

_____

The information to be released will be used for the purpose described below:

_____

I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it ad would then no longer be protected by federal privacy regulations. I may revoke or withdraw this authorization by notifying _____ in writing of my desire to revoke it. However, I understand that any action already taken in advance of this authorization cannot be reversed and revocation will not affect those actions. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization. This authorization will expire on _____ or 1 (one) year after the date of said authorization.

THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING

_____	_____	_____
Signature of Individual	Date	DOB or SS #

OR, if applicable:

_____	_____	_____
Signature of Individual Representative	Date	DOB or SS #