Renal Physicians of Montgomery County, P.A.

Diplomate in American Board of Internal Medicine Nephrology
www.rpmckidney.com

200 River Pointe Drive, Ste 120
Conroe, TX 77304
936-756-2555

17198 St. Luke's Way, Ste. 430
The Woodlands, TX 77384
936-271-3400

116A Medical Park Lane
Huntsville, TX 77340
936-756-2555

Patient Name:_____ DOB:_____ SS#_____

Telephone: home_____ Cell_____ Work_____

I authorize Renal Physicians of Montgomery County, P.A. to furnish information to insurance carriers concerning my illness and treatments if necessary to process my insurance claim(s). I hereby assign to Renal Physicians of Montgomery County, P.A. all payments for medical service rendered to myself. I understand that I am responsible for any amount not covered by any insurance including all office visits, procedures and injections.

_____ _____
(Signature of Patient) (Date)

There are times when a close friend, caregiver or relative calls our office to ask questions concerning your medical condition, treatment or account balance. We need your authorization to release this information. Without this information we will not be able to give out your personal information.

_____	_____	_____
(Name)	(Relationship)	(Phone Number[s])
_____	_____	_____
(Name)	(Relationship)	(Phone Number[s])
_____	_____	_____
(Name)	(Relationship)	(Phone Number[s])

I give my permission for information to be given to the people listed above. This information can include, but is not limited to, any and all medical information. Including office or hospital visits, billing & account information, appointments and medical records. I understand this information will or could be released to any of my other physicians or any physicians I may be referred to.

Medical Records Release: I give permission to Renal Physicians of Montgomery County to request and release any of my medical records to any physician that requests them for treatment of my medical care.

_____ _____
(Signature of Patient) (Date)

Welcome to Renal Physicians. Please fill out the information found below to the best of your ability.

Patient name_____ Date of Birth_____ SS# _____

Chief Complaint(reason you are coming to see us)_____

Present illness: Location of problem_____ Signs/Symptoms_____

Past Medical History: Have you ever had any of the following?

Condition....	No	Yes	Parent	Sibling		Condition....	No	Yes	Parent	Sibling
AIDS or HIV+						Measles				
Anemia						Migraine/Headaches				
Any other disease						Mitral Valve Prolapse				
Arthritis						Mumps				
Asthma						Pneumonia				
Back trouble						Polio				
Bladder infections						Rheumatic fever				
Bleeding tendency						Scarlet fever				
Blood Transfusion						Smallpox				
Bronchitis						Stroke				
Cancer						Thyroid disease				
Chickenpox						Tuberculosis				
Diabetes						Ulcer				
Diphtheria						Venereal Disease				
Epilepsy						Whooping cough				
Glaucoma										
Heart Disease						Date of last Chest XRay				
Hemorrhoids						Other				
Hepatitis						Other				
Hernia						Other				
High blood pressure						Other				
Hives or Eczema						Other				
Infectious Mono						Other				
Kidney disease						Other				
Low blood pressure						Other				

Allergic/Immunologic: (history of skin reaction or other adverse reaction)

Condition	Yes	No
Penicillin or other antibiotics		
Morphine, Demerol or other Narcotics		
Novocain or other Anesthetics		
Aspirin or other Pain Remedies		
Tetanus or other Serums		
Iodine, Merthiolate or other Antiseptic		
Other drugs/medications		

Previous Hospitalizations/Surgeries/Serious Illnesses: When? Hospital, City & State

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

HEALTH HISTORY

Thank you for selecting our healthcare team! We will strive to provide you with the best possible healthcare. To help us meet all your healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us - we will be happy to help.

Personal Information

Date _____

Birthdate _____

SS #/SIN _____

Name _____

Wishes to be called _____

☐ Male ☐ Female ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Address _____

City _____ State/Prov. _____ Zip/P.C. _____

Employer _____ Occupation _____

Referred by _____

Contact Information

Home Phone _____ Pharmacy Phone # _____

Work Phone _____ Ext. # _____

Cell Phone _____ E-Mail: _____

Where do you prefer to receive calls? ☐ Home ☐ Work ☐ Cell Phone

When is the best time to reach you? Time _____ Days _____

In the event of an emergency, who should we contact?

Name _____ Relationship _____ Work # _____ Home # _____

Insurance Information

Primary Insurance

Name of Insured _____

Relationship to patient _____

Insured's birthdate _____

SS #/SIN _____

Employer _____

Date Employed _____

Occupation _____

Insurance Company _____

Group # _____

Employee/Cert. # _____

Ins. Co. Address _____

Deductible _____

Amount already used _____

Max. annual benefit _____

Additional Insurance

Name of Insured _____

Relationship to patient _____

Insured's birthdate _____

SS #/SIN _____

Employer _____

Date Employed _____

Occupation _____

Insurance Company _____

Group # _____

Employee/Cert. # _____

Ins. Co. Address _____

Deductible _____

Amount already used _____

Max. annual benefit _____

MEDICATION LIST

PATIENT NAME .... BIRTHDATE ..... / ..... / ..... PATIENT # ....

ALLERGIES - DRUG REACTIONS

PHONE # ....

PHARMACY ....

PHONE # ....

PROBLEM(S)	MEDICATION/STRENGTH	DIRECTIONS	NUMBER REFILLS	NURSE TO REFILL	DATE	REFILLS					
				YES	START	DATE					
				NO	STOP	INITIALS					
				YES	START	DATE					
				NO	STOP	INITIALS					
				YES	START	DATE					
				NO	STOP	INITIALS					
				YES	START	DATE					
				NO	STOP	INITIALS					
				YES	START	DATE					
				NO	STOP	INITIALS					
				YES	START	DATE					
				NO	STOP	INITIALS					
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				NO	STOP	INITIALS					
				YES	START	DATE					
				NO	STOP	INITIALS					
				YES	START	DATE					
				NO	STOP	INITIALS					