MODULE 1
SWAN NEW PATIENT INFORMATION FORM
Universal New Patient Demographic Form

□ **Never seen** at SWAN

□ **Previously Seen** at SWAN

Front Office

Person calls in for a new patient appointment.

The following are the questions to be answered on that call:

1. **Name:** _____
2. **Date of Birth:** _____ 3. Age: _____ **4. SSN:** _____
5. Marital Status: _____ Single _____Married _____Divorced _____Widowed
6. What is your ethnicity? _____ Language: _____
7. How well do you speak English? _____Very Well _____Not Well _____Not at all
8. **Home Address:** _____

   _____
9. **Telephone Contacts:** **Home:** _____ **Work:** _____ **Cell :** _____
10. Emergency Contact (name and number): _____
11. Name and Address of Employer: _____

    _____

    _____
12. Work Status: ____Full-Time ____Part-Time ____Unemployed ____Student ____Retired (Military / Non-Military)
13. Referral Source –a) name and number, or b) indicate if self referred): _____
14. **Primary Care Physician (name and number):** _____
15. **Reason for referral:** _____
16. **Insurance Information** (**Name of provider, ID#, Group #, Mailing Address, Telephone/Fax numbers, Co-Pay**):

    a) Primary Insurance _____

    _____

    _____

    _____

    _____

b) **Secondary** _____

_____

_____

_____

_____

c) **Tertiary Insurance** _____

_____

_____

_____

_____

17. **Schedule Appointment. MD/Date/Time:** _____

18. **Do you have access to the internet?** _____

If the answer to this question is "yes", please have the patient go to our website at www.swaneph.com, select "Forms" from the menu on the left side of the home page, then click on "New Patient Medical Information Sheet". Instruct them to print the form, complete it, and take the completed form to the scheduled appointment on _____.

If the answer to the question is "no" please inform the patient that we will be sending by mailing a copy of our "New Patient Medical Information Sheet," which should be completed upon receipt and taken to the appointment on _____. Please let them know that if after two days the package has not been received, they should inform our office. If time does not allow for the package to be re-sent, they should be advised to arrive at the appointment half an hour before the time scheduled.

19. Would you like to have access to our Patient Portal? _____

I hereby authorize Southwest Atlanta Nephrology to release by mail or electronically, any information needed by my Insurance Carrier to process claims for payment. I also authorize my Insurance Carrier to forward payment(s) for Medical and/or Surgical benefits to the Physician(s) (i.e. provider of service with Southwest Atlanta Nephrology).

I understand that I am financially responsible for all services rendered to me whether they are or are not covered by my insurance.

_____ _____

Signature of Patient Date

Southwest Atlanta Nephrology
New Patient Information

Past Medical History

- ☐ Eye problems
- ☐ Blindness
- ☐ Cataracts
- ☐ Hearing problems
- ☐ High blood pressure
- ☐ Heart attack
- ☐ Irregular heartbeat
- ☐ Pacemaker or defibrillator
- ☐ Congestive heart failure
- ☐ COPD/emphysema
- ☐ Pneumonia
- ☐ Tuberculosis
- ☐ Asthma
- ☐ Heartburn
- ☐ Stomach or bowel ulcers
- ☐ Bowel disease
- ☐ Gallbladder disease
- ☐ Hepatitis
- ☐ Frequent urinary tract infections
- ☐ Problems urinating
- ☐ Prostate problem
- ☐ Kidney stones
- ☐ Stroke
- ☐ Seizures
- ☐ Paralysis or weakness
- ☐ Thyroid problems
- ☐ Diabetes
- ☐ Arthritis
- ☐ Gout
- ☐ HIV
- ☐ Cancer
- ☐ Anemia

Surgical History

Please list any surgeries that you have had. Please include hospital and year.

_____

_____

_____

Hospital of Choice: (Name the hospital that you prefer to use). _____

Family History

Father

☐ No significant Past Medical History

☐ Kidney Disease ☐ Diabetes ☐ Heart Disease ☐ Heart Failure ☐ Hypertension ☐ Stroke

☐ Is your father alive? _____ If so, how old is he?_____

☐ Is your father deceased? _____ If so, what age did he die? _____ Cause of death?_____

Mother

☐ No significant Past Medical History

☐ Kidney Disease ☐ Diabetes ☐ Heart Disease ☐ Heart Failure ☐ Hypertension ☐ Stroke

☐ Is your mother alive? _____ If so, how old is she?_____

☐ Is your mother deceased? _____ If so, what age did she die? _____ Cause of death?_____

Siblings

☐ No significant Past Medical History

☐ Kidney Disease ☐ Diabetes ☐ Heart Disease ☐ Heart Failure ☐ Hypertension ☐ Stroke

☐ How many are deceased? _____ ☐ Did any sibling die before age 50? _____

Children

□ No significant Past Medical History

□ Kidney Disease □ Diabetes □ Heart Disease □ Heart Failure □ Hypertension □ Stroke

How many are deceased? _____ □ Did any child die before age 50? _____

Social History

Marital Status

□ Single □ Married □ Divorced □ Separated □ Widowed □ Other _____

Living Arrangement

□ Live alone; If not, please circle one below:

□ Live with spouse / caregiver / significant other: Name _____

□ Live in Nursing Home: Name of Nursing Home_____

Who is your next of kin? _____ What is your relationship to him/her? _____

Education History

What is your occupation? _____ What is the highest level of education completed? _____

Habits

Smoking

□ I currently smoke everyday □ I currently smoke on some days □ I am a former smoker

□ I have never smoked □ I have smoked off and on, previously □ Unknown

Cigarettes □ Yes □ No □ _____ packs per day smoked. _____ # of years.

Cigars □ Yes □ No Smokeless tobacco □ Yes □ No Pipes □ Yes □ No

Alcohol

□ I have never drank alcohol □ I drink only on special occasions (social) □ I drink 1-3 drinks a day

□ I drink more than 3 drinks a day □ I used to drink, but have stopped. When? _____

Illegal Drugs

□ I have never used illegal drugs □ I have used illegal drugs in the past Type: _____

□ I am currently using illegal drugs Type: _____

Ethnicity

What is your ethnic background? □ White □ Black/African American □ American Indian/Alaskan Native

□ Asian □ Chinese □ Filipino □ Guamanian/Chamarro □ Japanese □ Korean

□ Native Hawaiian/Other Pacific Islander □ Samoan □ Vietnamese □ Other

What is your nationality? _____ In what country were you born?_____

What is your religion? _____

PATIENT ACKNOWLEDGMENT AND CONSENT

For All Patients Seen at SWAN After September 23, 2013

I have been given a copy of Southwest Atlanta Nephrology, P.C. Notice of Privacy Practices, version effective September 23, 2013. I consent to the uses and disclosures of my health information as outlined in the Notice.

_____ _____

Signature of Patient or Representative Date

_____

Print Name

_____

Relationship of Representative to Patient

Please describe the Representative's authority to act on behalf of Patient: _____

_____

_____

FOR [ENTITY] USE ONLY

If acknowledgment of receipt of the Notice of Privacy Practices is not obtained from the patient or the patient's representative, please explain your efforts to obtain acknowledgment and the reason you could not obtain it:

_____

_____

_____

_____

_____