Kingwood Kidney Associates

Sowmya Puthalapattu M.D.
Chinonye Ogbonnaya-Odor M.D.
Office (281)401-9540 Fax (281)715-4046

Date: ______________________

Patient Information

Patient Name: ____

Date of Birth: _____/_____/_____ S.S. #_______-_______-______ Male ________Female________

Mobile: (_______) _________-________ Home: (______) _________-________

Email: ____

Address: ____City: ___________________ZIP_____________

Demographics

Ethnicity: ___________________________ Language: ____________________ Race: ________________

Emergency

Name: ____

Phone: _______________________________________ Relationship: _____________________________

PCP (Primary Care Physician): _________________________________Phone (______) _______-________

Referring DR: _______________________________________Phone (_______) _________-_____________

Pharmacy Information

Pharmacy: ____ Phone: (_______) __________-__________

Pharmacy Address: ____

City: ____ State: _____________ Zip: ___________________

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Insurance Information

Primary Insurance

Insurance Name: ____

Member ID: __________________________ Group Number: ____

Secondary Insurance

Insurance Name: ____

Member ID: ___________________________ Group Number: _______________________________________

Signature of Patient: ____

Signature of Guardian: ____

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1. How would you rate your Current general health?

○ Very poor ○ Poor Average ○ Good ○ Very good

2. Circle if you have or had any of the following below

Diabetes	Now Past	Anemia	Now Past
High Blood Pressure	Now Past	Peptic Ulcer	Now Past
Stroke	Now Past	Acid Reflux (heartburn)	Now Past
Heart Disease or CHF	Now Past	Kidney Disease	Now Past
Heart Attack	Now Past	Thyroid Disease	Now Past
Angina	Now Past	Arthritis	Now Past
Emphysema or COPD	Now Past	Back Pain	Now Past
Asthma	Now Past	Head Trauma	Now Past
Tuberculosis	Now Past	Severe Headaches	Now Past
Lung Disease	Now Past	Epilepsy (Seizures)	Now Past
Nasal Allergies	Now Past	Fainting	Now Past
Runny or Blocked Nose	Now Past	Depression	Now Past
Hormonal Problem	Now Past	Anxiety Disorder	Now Past
Urological Problem	Now Past	Problems with alcohol	Now Past
Prostate Disease	Now Past	Problems with drugs	Now Past

3. Have you ever been exposed to or tested positive for Human Immunodeficiency Virus (HIV) or have Aids? Yes No

   If Yes, please elaborate: ____

4. Please list hospitalization reason and date (as best as you can remember).

Reason for Hospitalization	Date

5. Please give any important details about your medical Conditions Below

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Medical Information Release Form (HIPAA Release Form)

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

Release of Information

[_] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released

to:

[_] Spouse____

[_] Child(ren)____

[_] Other____

[_] Provider ____

[_] Information is not to be released to anyone. This Release of Information will remain in effect until terminated by me in writing.

Signed: ______________________________________ Date: ____/____/_____

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Please list medications below:

Medication	Dosage	How often?

Please list any drug allergies: ☐ NKDA (no known drug allergies)

____

____

____

____

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Life Style and Habits

o Disabled   o Retired   o Occupation:
Education: o Some High School   o High School Diploma   o College   o Years
Marital Status: o Single o Married o Widowed o Divorced o Separated
Smoker: o Yes   o No   o Quite since:
Alcohol: o Current   o Never   o Former
Caffeine: Cups/Days
Recreational Drugs Use: o No   o Yes   o Former

Check All the diseases that run in your family.

Disease	Relationship	Age	Living/Deceased	Type	Abbreviations
Alcoholism					Father(F)
Cancer					Mother(M)
Depression					Husband (H) Wife(W)
Diabetes mellitus					Sister(S) Brother(B)
Heart Disease					Grandfather (GF)
High Blood Pressure					Grandmother(GM)
High Cholesterol					Son(SN) Daughter (D)

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Patient Responsibility

Patient Name:	
Date of Birth:	
SSN #:	

- I, mentioned above, here by affirm that I will be responsible for any payments (includes but not limited to co-pay, co-insurance, deductible, lab tests) not covered by my insurance and will pay such amounts within 30 days from the date on the statements that I receive from the doctor's office.
-
- If I am unable to pay such amounts in one payment, I will work with the doctor's office to set up a payment plan and will pay the amounts according to such a plan.
- I understand that the physician may order lab tests that may or may not be covered by my insurance. In case if such tests are not covered by my insurance, I am responsible to pay for such tests and the physician is not liable in any such cases.
- I understand that if Medicare is my primary insurance, and I do not hold a supplemental plan, the remaining 20% balance is my responsibility.
- I understand that a minimum of $35.00 will be assessed for checks that are returned due to insufficient funds and I will pay such fee in addition to my dues to the office in case if my checks are returned.
- I understand there will be a **25.00 charge for a No Show/No Call 24-hour advance notice.**

_______________________________ _______________________

Signature Date

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