KIDNEY HEALTH
SPECIALISTS

Emilian Cristea MD

Patient Registration Form

Name:_______________________________________ **DOB**:___/___/_____ **Social Security#**:___________________

Address:____ **City**:________________ **State**:_____ **Zip**:_________

E-mail Address: ____ **Language**:______________________________

Home Phone : (____) ____ - __________ **Cell Phone**: (____) ____ - ____________ **Sex**: □ Male □ Female

Marital Status: □ Single □ Married □ Divorced □ Widowed □ Prefer Not to Answer

Primary Insurance:____ **Member ID**:____________________________

Secondary Insurance:______________________________________ **Member ID**:____________________________

PCP: _______________________**Phone Number:** (____) ____ - ____ **Referring Provider**:_____________________

Local Pharmacy: ____________________________________ **Phone Number**:______________________________

Major Cross Streets:____

Mail Order Pharmacy:____

Race:
□ Asian
□ Black/African American
□ Caribbean
□ Hispanic
□ Native Hawaiian/ Other Pacific Islander
□ White
□ Other
□ Prefer Not to Answer

Ethnicity:
□ Hispanic / Latino
□ Non-Hispanic
□ Prefer Not to Answer

I authorize Kidney Health Specialists to leave messages regarding my treatment, including lab or imaging test results, names of medications, information pertaining to my treatment and office updates by the following method:

□ Home answering machine □ Cell phone/Voicemail □ Text □ E-mail: ______________________________

I will ensure all information is up to date at every visit.

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Medical History:

	Y	N		Y	N		Y	N
Kidney disease			Asthma			Stroke		
Kidney Stones			Thyroid Problems			Autoimmune disease		
Diabetes/High Blood Sugar			Anemia			Skin disease		
High Blood Pressure			Bleeding Problems			Depression		
High Cholesterol			Liver Disease			Anxiety		
Irregular Heartbeat			Bleeding from Bowels			Cancer		
Heart Attack			Prostate Problems			Type:		
Congestive Heart Failure (CHF)			Chronic Obstructive Pulmonary Disease (COPD)			Other:		
Blood Clot in Legs or Lungs (DVT/PE)			Arthritis					

Surgical History:

	Y	N	Year		Y	N	Year
Kidney Removal/Nephrectomy				Appendix Removal			
Bladder Surgery				Gallbladder Surgery			
Prostate Surgery				Abdominal Surgery			
Open Heart Surgery				Back Surgery			
Cardiac Catheterization				Hysterectomy			
Neck Artery Surgery				Other			

Allergies:

List any allergies you have: ☐ No Known Drug Allergies

____

____

Hospitalizations in the last year:

____

____

Medications: *Please list any medications you are currently taking (including OTC medications).*

____

____

____

____

Family Medical History:

	Kidney Disease	Heart Disease	Diabetes	Hypertension	Stroke	Autoimmune Disease	Cancer	Other
Mother								
Father								
Daughter								
Son								
Grandmother								
Grandfather								
Siblings								

Social History:

Have you ever smoked? □ Yes □ No

- If you stopped smoking when did you quit? _____
- If yes, number of years? _____
- If you currently smoke, how many packs per day? _____
- Do you use smokeless tobacco? (i.e. chewing tobacco) □ Yes □ No

Do you drink alcohol? □ Yes □ No

- If yes, how much/week? ____

Do you currently use recreational drugs? □ Yes □ No

- If yes, which drugs? ____

Are you on a special diet? □ Yes □ No

- If yes, please describe: ____

Do you exercise? □ Yes □ No

- If yes, what type and how often? ____

Marital Status: □ Single □ Married □ Divorced □ Widowed □ Other

Occupation: ____

What was the date of your last Flu vaccine? (Month/Year) _____/______________

Did you get the COVID 19 vaccine? □Yes □ No

General constitutional	Y	N		Urinary	Y	N		Skin	Y	N
Chills/fevers				Blood in Urine				Oral ulcers		
Fatigue				Increased Urine				Rash		
Night Sweats				Difficulty Urinating				Itching		
Weight Loss				Pain with Urination				Skin Discoloration		
Head/Eyes/Nose	**Y**	**N**		**Hematology**	**Y**	**N**		**Genital - Woman**	**Y**	**N**
Headache				Anemia				Painful Periods		
Diabetic eye disease				Easy Bleeding				Birth Control Use		
Nose bleeds				Swollen Glands/Nodes				Sexual Dysfunction		
Respiratory	**Y**	**N**		**Endocrine**	**Y**	**N**		**Genital - Man**	**Y**	**N**
Cough				Heat Intolerance				Difficult Urination		
Shortness of Breath				Cold Intolerance				Dribbling		
Wheezing				Excessive Thirst				Sexual Dysfunction		
Cardiovascular	**Y**	**N**		**Musculoskeletal**	**Y**	**N**		**Psychiatric**	**Y**	**N**
Chest pain				Back Pain				Depression		
Irregular Heartbeat				Morning Stiffness				Anxiety		
Ankle Swelling				Joint Pain				Bipolar		
Gastrointestinal	**Y**	**N**		**Neurological**	**Y**	**N**		**Others:**		
Reflux/Heartburn				Seizure						
Abdominal pain				Dizziness						
Nausea/Vomiting				Muscle Weakness						
Diarrhea				Headache						
Constipation				Fainting						
Blood in Stool/Black Stool				Numbness in Fingers/ Toes						

Review of Systems:

Date of Last Menstrual Period (LMP): ___/____/_______ Number of pregnancies: __________________

Complications in pregnancy (e.g., diabetes, high blood pressure, protein in the urine): □ Yes □ No

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7369 Sheridan Street, Suite 300
Hollywood, FL 33024 | 954-226-0121 | www.cristeamd.com | kidney@cristeamd.com

Authorization for Release of Medical Records

Patient Information:

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

Address: ____

City: ________________________ State: __________ Zip: _____________ Phone: (____) ____ -__________

Release of Medical Information From:

Facility/Provider: ____

Address:____ City: ____________________

State: ________ Zip: _____________ Phone: (____) ____ -_________ Fax number: (____) ____ -_________

Release of Medical Information To:
Kidney Health Specialists
7369 Sheridan Street Suite 300, Hollywood, Florida 33024
Phone: (954) 226 - 0121 Fax: (866) 981 - 2156
Email: kidney@cristeamd.com

Purpose of Disclosure: ☐ Continuation of Care ☐ Other: __________________________

Please include all information regarding assessment, diagnosis, treatment, and laboratory results for the above listed patient. Date of service release FROM: ____ / _________ TO: _____ / _______

I understand that I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the practice manager. I understand that the revocation will not apply to information that has already been released in response to this authorization. This authorization and consent will expire one year from the date of authorization written below, unless revoked by me (or my legal representative) through written notice presented to Kidney Health Specialists.

I understand and acknowledge that the requested health information may contain information regarding physical and mental illness, sexually transmitted diseases, HIV test results or diagnosis, and alcohol or drug abuse.

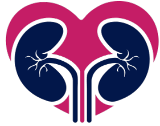
I understand that treatment, payment, enrollment, or eligibility for benefits will not be based on whether I sign this authorization.

I understand that the sender of my health information may charge for the service of disclosing medical information and I am responsible for inquiring about these potential charges.

I understand that authorizing the disclosure of this health information is voluntary. You may refuse to sign this authorization. Such refusal will not affect your ability to obtain treatment except to the extent that the information being requested may assist your health care provider in determining appropriate treatment.

I have read the above foregoing authorization for release of information and do hereby acknowledge that I am familiar and fully understand the terms and conditions of this authorization.

____	______________________________	____ /_____ / _________
Patient Name	**Signature**	**Date**



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Authorizations and Consents

Access to Prescription History:
Our medical practice has adopted an electronical medical records system which will further enhance the quality of our services. This system allows us to collect and review your medical history. A medication history is a list of prescription medicines that we or other doctors have prescribed to you. This list is collected from a variety of sources, including your pharmacy and your health insurer. An accurate medication history is very important in helping us treat you properly and avoid potentially dangerous drug interactions. By signing this consent form you give us permission to collect your medication history without limitation or exclusion as is required and/or reasonably necessary for your care and treatment. Please understand that your medication history might not include over the counter medicines, supplements, or herbal remedies.

Authorization to Share Health Information:
I authorize Kidney Health Specialists to release any information regarding my treatment, including lab or imaging test results, names of medications, information pertaining to my treatment and office updates. This includes leaving messages on the designated contact phone numbers. Kidney Health Specialists may not release information to the named individuals and or entities unless you identify them below.

Emergency contact:

Name: ______________________________________ Relation: ___________________ Phone: (____) ____ - ______

Name: ______________________________________ Relation: ___________________ Phone: (____) ____ - ______

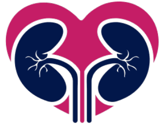
Name: ______________________________________ Relation: ___________________ Phone: (____) ____ - ______

Acknowledgement of Receipt of HIPAA Privacy

I understand that Kidney Health Specialists may use and disclose my protected health information for purposes of treatment, payment, and health care operations. I also acknowledge that I have received, have been offered, or have received in the past a copy of the notice of privacy practices for Kidney Health Specialists, which provides information about how the physicians, facilities and individuals involved in my care may use and disclose my protected health information. As provided in the notice, the terms of the notice may change. To obtain a copy of any current notice, I may contact the office at (954) 226-0121. I understand that I have the right to request that the practice restrict how my protected health information is used or disclosed for treatment, payment, or healthcare operations, but I also understand that the practice is not required to agree to a requested restriction.

____ ____________________________ ____ /_____ / _________

Patient Name **Signature** **Date**



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Patient Financial Agreement

Thank you for choosing us as your Nephrology health care provider. We are committed to being a partner in providing conscientious medical care for you. Payment of the bill is considered an important part of that partnership. Thank you for reading our financial agreement. Please let us know if you have questions or concerns.

The following is a statement of our Financial Policy, which we require you to read and sign.

It is your responsibility:

- To understand your benefits plan.
- To know if a referral is required.
- The know if pre-authorization is required prior to a procedure.
- To know what services are covered.

Full payment for self-pay patients, co-payments and deductibles are due at the time of service. You may also be asked to pay your coinsurance at the time of service.

We accept cash, checks, Visa/ MasterCard/ Discovery/ AMEX. Any other arrangements must be made in advance with our Billing Office.

Your insurance policy is a contract between you and your insurance company. Payment of your bill is ultimately your responsibility. Kidney Health Specialists contract with and bills most insurance carriers. If you are insured by a company with which we do not contract, we can supply you with a statement of your charges. You may submit this along with any additional forms your insurance requires, to your insurance company.

1. I have read and agree to this financial agreement.
2. I authorize and consent to the release of medical information necessary to bill and process insurance claims.
3. I authorize payment of medical benefits directly to the physician.
4. If we cannot successfully collect on an outstanding balance, and payment arrangements are not established within 30 days of statement, the cost of collection, including reasonable attorney fees shall be included as part of the obligation dues

______________________________	____________________________	____ /_____ / _________
Patient Name	**Signature**	**Date**

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Policies and Procedures Agreement

In the effort to serve all our patients equally, fairly and to the best of our ability, we ask that you review and understand our Patient Policies and Procedures.

Late Policy. Every effort is made to keep our physicians schedules on time therefore if you are more than 15 minutes late, we cannot guarantee that you will be seen immediately, but we will do our best to work with you into the schedule as time permits. If schedule is full you will be asked to reschedule your appointment to a later date.

Missed/Cancelled Appointments. Every effort is made to accommodate our patients request for appointment. Therefore, it is important that you make every effort to keep your scheduled appointment.

Transferring of Records. All patients must sign a records release form to have their records copied, electronically downloaded, or sent to another provider or organization. There is no fee to transfer records directly to another provider or health care organization.

Payment for Services for Patients with Insurance. According to your health insurance plan you are responsible for paying your copayment/coinsurance at the time of service.

Payment for Services for Patients without Insurance. You will be responsible for payment by cash, check, credit card on the day of service.

Return Checks. There is a $50 fee for any check returned by your bank.

_______________________________________	___________________________	____ /_____ / _________
Patient Name	**Signature**	**Date**