☐ Dr. Prashanth Kumar
☐ Dr. Opeyemi Oladele

☐ New Patient
☐ Existing Patient (Update)

12675 Hesperia Road • Victorville, CA 92395
Phone: 760-241-3306 • Fax: 760-241-6243

PATIENT DEMOGRAPHICS

First Name:	SSN Number:
Middle Name:	DOB: / AGE:
Last Name:	Gender: ___ Male ___ Female
Preferred Name:	*Ethnicity:* ___ Hispanic or Latino ___ Non-Hispanic or Latino ___ Unknown
Address 1:	
P.O Box	
City:	Other___
State:	*Race:* ___ White ___ Black / African American ___ American Indian / Alaskan ___ Asian ___ Chinese ___ Filipino ___ Guamanian / Chamorro ___ Japanese ___ Korean ___ Native Hawaiian / Other ___ Samoan ___ Vietnamese ___ Other
Zip:	
Home Phone:	
Cell Phone:	
Preferred Method of Contact: ___ Home Phone ___ Work phone ___ Mail ___ Cell phone ___ E-Mail :___	Primary / Preferred Language:

Consent Name:	*Relationship:*	*Phone Number:*
Emergency Contact:	Relationship:	Phone Number:
Emergency Contact:	Relationship:	Phone Number:

PHARMACY INFORMATION

Name of Pharmacy:	
Pharmacy Address:	Business Phone:
City & State:	Zip:

ASSIGNMENT AND RELEASE

I, the undersigned certify that I have insurance coverage with ___________________ and assign directly to Dr. ___________ all insurance benefits if any otherwise payable to me for services rendered. I understant that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefit. I authorize the use of the is signature on all insurance submissions.

Signature:	Relationship:	Date:

PAST MEDICAL HISTORY

Category		
Ichemic heart disease	___ Heart attack ___ Angina ___ Angioplasty	___ Coronary Stent ___ CABG
EENT	___ Blindness ___ Cataracts	___ Hearing problems ___ Glaucoma
Cardiovascular	___ High Blood Pressure ___ Atrial fibrillation ___ Pacemaker ___ High Cholesterol	___ AICD ___ Valvular heart diease ___ Congestive heart failure ___ Mitral valve prolapse
Respiratory	___ COPD ___ Chronic bronchitis ___ Asthma ___ Emphysema	___ Pneumonia ___ Tuberculosis ___ Sleep Apnea
Gastrointestinal	___ GERD ___ Stomach/Bowel ulcers ___ Gall Bladder disease ___ Hepatitis	___ Inflammatory bowel disease ___ Irritable bowel syndrome ___ Gluten intolerance ___ Lactose intolerance
Genitourinary	___ Kidney Disease ___ Enlarged prostate	___ Kidney Stones ___ Frequent UTI's
Musculoskeletal	___ Gout ___ Osteoarthritis	___ Osteoporosis
Neurological	___ Stroke ___ Multiple Sclerosis ___ Seizures	___ Parkinson's ___ Dementia
Psychiatric	___ Depression	___ Anxiety disorder
Endocrine	___ Diabetes (Type:____________) ___ Hypothyroidism ___ Hyperparathyroidism	___ Hyperthyroidism ___ Adrenal insufficiency
Hematology	___ Cancer ___ Anemia ___ Sickle cell Disease	___ Sickle cell trait ___ Blood Transfusion ___ Thalassemia
Immuno/Allergy	___ HIV ___ AIDS	___ Rheumatoid arthritis ___ Lupus

SURGICAL HISTORY

___ NO

___ YES

- ___ Appendectomy
- ___ CABG
- ___ Carotid endarterectomy
- ___ Cataract Surgery
- ___ Gall bladder removal
- ___ Gastric bypass
- ___ Hemorrhoidectomy
- ___ Hernia repair
- ___ Hip Replacement
  - ___ Left
  - ___ Right
  - ___ Bilateral
- ___ Knee replacment
  - ___ Left
  - ___ Right
  - ___ Bilateral
- ___ Prostatectomy
- ___ Nephrectomy
- ___ Renal transplant
- ___ Thyroidectomy
- ___ Tonsillectomy
- ___ Valve replacement
- ___ AV fistula
- ___ AV graft
- ___ PD catheter
- ___ OTHER

____

____

____

FAMILY HISTORY

Illnesses : check boxes to whom it applies

Kidney Disease

___ None ___ Father ___ Mother ___ Sibling ___ Child

Diabetes

___ None ___ Father ___ Mother ___ Sibling ___ Child

High Blood Pressure

___ None ___ Father ___ Mother ___ Sibling ___ Child

Ischemic Heart Disease also known as Coronary Artery Disease

___ None ___ Father ___ Mother ___ Sibling ___ Child

Cancer

___ None ___ Father ___ Mother ___ Sibling ___ Child

Stroke

___ None ___ Father ___ Mother ___ Sibling ___ Child

Gout

___ None ___ Father ___ Mother ___ Sibling ___ Child

ADPKD

___ None ___ Father ___ Mother ___ Sibling ___ Child

Dementia

___ None ___ Father ___ Mother ___ Sibling ___ Child

Is your Father: ___ Living ___ Deceased: Age of Death_____ Cause____________ ___ Unknown

Is your Mother: ___ Living ___ Deceased: Age of Death_____ Cause____________ ___ Unknown

SOCIAL HISTORY

General

Current Marital Status

___ Married ___ Single ___ Divorced ___ Separated ___ Widowed

Living Arrangement

___ Alone ___ With Spouse ___ With Significant Other
___ Family Member ___ In Home Caregiver ___ Assisted living facility

Occupation

___ Retired
___ Employed
___ Unemployed
___ Student

Former Occupation:__________________
Current Occupation:__________________ ___ Full time ___ Part time
Former Occupation:__________________

Functional/ Cognitive

___ No impairment ___ Limited mobility ___ Poor vision or blindness
___ Hearing loss ___ Memory deficit ___ Transportation challenges

Habits

Tobacco Use

____ Never Used

____ Current User Date Started __________
___Cigarettes ___Pipes ___ Cigars
___ Snuff ___ Chewing Tobacco

____ Former User ________ Date Started ________ Date Ended

Alcohol Use

____ Never Used

____ Current User ___ Occasional social drink
___ 1-2 drinks per day
___ 3 or more drinks per day

____ Former User
Year Quit ___________

Recreational Drug Use

- ____ Never Used
- ___ Current User
  - ___ Marijuana
  - ___ Amphetamines
  - ___ LSD
  - ___ Heroin
  - ___ Ecstasy
  - ___ Opium
  - ___ Cocaine
  - ___ Barbiturates
  - ___ Other
- ____ Former User
  - Year Quit ____________

REVIEW OF SYSTEMS

Have you recently had:

Constitutional

- ___ Fever
- ___ Weight gain
- ___ Weight Loss
- ___ Fatigue
- ___ Chills
- ___ Weakness

HEENT

- ___ Vision Impaired
- ___ Eye Pain
- ___ Redness
- ___ Color Blindness
- ___ Double Vision
- ___ Hearing loss
- ___ Ear Pain
- ___ Sinus problems
- ___ Sore Throat
- ___ Nose bleeds
- ___ Headache
- ___ Hoarseness
- ___ Tinnitus
- ___ Vertigo

Respiratory

- ___ Shortness of breath
- ___ Shortness of breath at rest
- ___ Shortness of breath with activity
- ___ Pain with breathing
- ___ Cough
- ___ Wheezing
- ___ Blood in sputum
- ___ Night sweats

Cardiovascular

- ___ Chest pain
- ___ Palpitations
- ___ Claudication
- ___ Orthopnea
- ___ Edema
- ___ PND

Gastrointestinal

- ___ Abdominal Pain
- ___ Nausea
- ___ Diarrhea
- ___ Heartburn
- ___ Trouble swallowing
- ___ Vomiting
- ___ Constipation
- ___ Anorexia
- ___ Indigestion

Genitourinary

- ___ Urinary Urgency
- ___ Urinary burning or pain
- ___ Blood in urine
- ___ Urinary frequency
- ___ Urinary hesitancy
- ___ Foamy urine
- ___ Incontinece
- ___ Nocturia

Musculoskeletal

- ___ Back Pain
- ___ Neck Pain
- ___ Joint Pain
- ___ Muscle Pain
- ___ Arm Weakness
  - ___ Left ___ Right ___ Both
- ___ Leg Weakness
  - ___ Left ___ Right ___ Both

Skin

- ___ Rash
- ___ Itching
- ___ Scaling
- ___ Dryness
- ___ Color Change

Neurological

- ___ Numbness
- ___ Tremors
- ___ Seizures
- ___ Tingling
- ___ Fainting

Psychiatric

- ___ Depression
- ___ Insomnia
- ___ Anxiety

Endocrine

- ___ Heat intolerance
- ___ Cold intolerance
- ___ Excessive thirt
- ___ Excessive urination

Hematology

- ___ Bleeding gums
- ___ Easy Bruising

Immuno / Allergy

- ___ Seasonal allergies
- ___ Hives

Please list all the medication and supplements you take:

If you run out of space please continue on the back!

Medication		Please circle one:					Times taken a day
	MG	Capsule	Tablet	Inhale	Inject	Other	
		Capsule	Tablet	Inhale	Inject		
		Capsule	Tablet	Inhale	Inject		
		Capsule	Tablet	Inhale	Inject		
		Capsule	Tablet	Inhale	Inject		
		Capsule	Tablet	Inhale	Inject		
		Capsule	Tablet	Inhale	Inject		
		Capsule	Tablet	Inhale	Inject		
		Capsule	Tablet	Inhale	Inject		
		Capsule	Tablet	Inhale	Inject		
		Capsule	Tablet	Inhale	Inject		
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		Capsule	Tablet	Inhale	Inject		
		Capsule	Tablet	Inhale	Inject		

Allergies to Medications:	
Name:	*Reaction:*

Acknowledgement of Receipt of Notice
High Desert Nephrology

Contact: Privacy Officer: Danette Voss at 760-241-8063

Name of Patient: ______________________________

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices.

Circle One: Yes No I would like to receive a copy of any amended Notice of Privacy Practices by e-mail at: ______________________________.

Signed: ______________________________ Date: ______________________________

Print Name: ______________________________ Telephone: ______________________________

If not signed by the patient, please indicate your relationship to the patient:

- ❑ parent or guardian of minor patient
- ❑ guardian or conservator of an incompetent patient
- ❑ beneficiary or personal representative of deceased patient

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***For Office Use Only*:**

- ❑ Signed form received by: ______________________________
- ❑ Acknowledgment refused:

Efforts to obtain:

____

____

Reasons for refusal:

____

____

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Adopted 11/19/13

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HIPAA PATIENT COMMUNICATION FORM

A. Family and Friends. It is the office policy of High Desert Nephrology not to release confidential medical information regarding your treatment to family members or friends, except for (i) parent/legal guardian, (ii) other persons authorized by the patient, (iii) as we may reasonably infer from the circumstances (for example, if you bring a family member or friends into the exam room, we will assume, unless you object, that that person is entitled to receive information regarding your treatment, (iv) in emergency situations, or (v) other as otherwise permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

If you anticipate that you will need or want our medical information to be provided to family members, friends, or caretakers/babysitters, please indicate below, so that we may best serve you. By signing below, you authorize the following people to receive information regarding your treatment or care: (If you wish to add names later, please confirm this in writing, or call our staff.)

Spouse:	
Parent:	
Other:	

B. Alternative Communications: You are also entitled to specify alternative, reasonable means of communication, if you do not wish to be contacted by us in a certain way.

I hereby request the following means of contact only:

Home phone	Yes / No	Detailed message:	Call back only:
Cell phone	Yes / No	Detailed message:	Call back only:
Mail		n/a	n/a
E-mail:		Email address:	

PRINTED NAME ______________________ DATE: ______________________

Patient/Parent/Guardian Signature: ______________________

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HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA | PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) | TRICARE CHAMPUS (Sponsor's SSN) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED: Self, Spouse, Child, Other

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. PATIENT STATUS: Single, Married, Other; Employed, Full-Time Student, Part-Time Student

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

a. OTHER INSURED'S POLICY OR GROUP NUMBER

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

c. EMPLOYER'S NAME OR SCHOOL NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10. IS PATIENT'S CONDITION RELATED TO:

a. EMPLOYMENT? (Current or Previous) YES NO

b. AUTO ACCIDENT? PLACE (State) YES NO

c. OTHER ACCIDENT? YES NO

10d. RESERVED FOR LOCAL USE

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. EMPLOYER'S NAME OR SCHOOL NAME

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes,* return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE | 17a. | 17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. ___ . ___ 3. ___ . ___

2. ___ . ___ 4. ___ . ___

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1									NPI	
2									NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. b.

33. BILLING PROVIDER INFO & PH # ( )

a. b.

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)