Summit Nephrology Medical Group, Inc.

Welcome to our practice. We are committed to providing the best, most comprehensive care possible. Please assist us by Providing the following information. All information is confidential and is released only with your consent.

Patient Name Today's Date	Date of Birth Sex Age
Marital Status (please circle one) Single Married Divorced Widowed	Parent Name (if patient is a minor)
Patient's Social Security Number (Required)	California Driver's License No.
Home Address	City State Zip
Mailing Address (if different)	City State Zip
Home Telephone Number	Work Telephone Number
Occupation	Employer's Name
Employer's Address	City State Zip
Spouse Name Spouse D.O.B.	Spouse's Employer
Referring Physician	Address Phone/Fax
Primary Care Physician (if different from referring physician)	Address Phone/Fax
PHARMACY NAME	PHARMACY PHONE NUMBER
NOTIFY IN CASE OF EMERGENCY	
Name	Relationship
Address	City State Zip
Home Telephone	Work Telephone
Nearest Relative (not living with you)	Address
Home Telephone	Work Telephone
FINANCIAL INFORMATION: PERSON RESPONSIBLE FOR ACCOUNT (if other than patient)	
Name	Telephone
Address	City State Zip
Primary Insurance Company	Claim Address
Subscriber's Name	Subscriber's Date of Birth
Subscriber's SSN#	Insurance ID No.
Secondary Insurance Company	Claim Address
Subscriber's Name	Subscriber's Date of Birth
Subscriber's SSN#	Insurance ID No.

Please Read Our Financial Policy Statement and Agreement on Next Page.

Summit Nephrology Medical Group, Inc.

151 N. Sunrise Ave., Ste. 1205 Roseville, CA 95661 916-789-1505

Phone Consult Policy

I understand that the preferred method of Health Online and I have been offered en	•
Signature	Date
Decline Acc	ept
Email address:	
<u>Financial Policy</u>	
I understand that I am financially response rendered. I understand that my insurance I am responsible for any remaining balance denied due to non-coverage. I authorize Inc. to bill my insurance and accept paymendered.	will be billed as a courtesy and that ce, copayments or charges that are Summit Nephrology Medical Group,
Name	D.O.B
Signature	Date

HIPAA

Summit Nephrology Medical Group, Inc. 151 N. Sunrise Ave., Ste. 1205 Roseville, CA 95661

Tami Clouse, Practice Manager, 916-789-1505 Privacy Officer

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that a copy of any amended Notice of Privacy Practices will be available at each appointment.

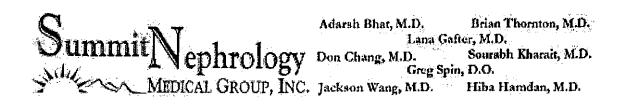
Signed: Date: Print Name: Telephone: If not signed by patient, please indicate relationship: Parent or guardian of minor patient. Guardian or conservator of an incompetent patient. Name and address of Patient:
If not signed by patient, please indicate relationship: Parent or guardian of minor patient. Guardian or conservator of an incompetent patient. Name and address of Patient:
□ Parent or guardian of minor patient. □ Guardian or conservator of an incompetent patient. Name and address of Patient:
Guardian or conservator of an incompetent patient. Name and address of Patient:
Name and address of Patient:
Por la presente reconozco que recibí una copia del Aviso de esta práctica médica de prácticas de privacidad. Además, reconozco que una copia del aviso actual será fijada en la zona de recepción, y que una copia de la Notificación de Prácticas de Privacidad modificada estará disponible en cada cita.
Finnado: Fecha:
Imprimir Nombre: Telefono:
Si no está firmada por el paciente, por favor indique la relación



Consent to Receive Text Message Appointment Reminders

By signing below, I authorize Sutter Health and its affiliates to contact me by automated SMS text message for appointment reminders.

	y to messages sent by Sutter Health or its affiliates
under my cell phone plan.	
My text/mobile phone number is: ()	Patient initials
messages. I may opt-out of receiving these co	rize Sutter Health or its affiliates to send me text ommunications at any time by calling the Service OP to 622622. Please allow 2-3 business days for
that individually identifiable health information contained in such text may be misdirected, dist parties. Information included in text messages appointments, name of physician, and physician	- · · · · · · · · · · · · · · · · · · ·
	<u> </u>
from Sutter Health and its affiliates to the pho-	to receive text messages via automated technology ne number that I have provided.
r	r
Patient Name:	DOB:
Signature:	,
(Patient/legal representative)	(Relationship if other than patient)
Printed Name:	, Date:
(Legal representative)	
Fax: Patient Services Contact Center	
Attn: My Health Online (877) 607-6484	
Mail: Patient Services Contact Center	
Attn: My Health Online	
PO Box 255386	
Sacramento, CA 95865-5386	

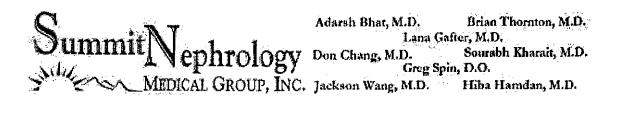


Patient Contact Information Restriction

In general, the HIPAA privacy rule gives the individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of their home.

Print Name	Date
Patient Signature	DOB
Leave message with call back number only	
Ok to leave message with detailed information	
Cell Phone Number:	
Leave message with call back number only	
Ok to leave a message with detailed information	
Home Telephone Number:	
· · · · · · · · · · · · · · · · · · ·	

I wish to be contacted in the following manner:



Summit Nephrology Medical Group Inc is required by law to maintain the privacy of our patient's health information. With your written approval, we may **verbally** disclose your health information to others, including designated family members, friends, or others who are involved in your health care.

<u>Please Print</u>		
Patient's Name:	DOB:	
Address:	City:	Zip:
I authorize the following person(s) to rec	eive verbal information from Sur	mmit Nephrology Medical
Group INC regarding my health care.		
Family Member:	Phone	::
Family Member:	Phone	;:
Family Member:	Phone	:
Other (Friend, Caregiver):	Phone	::
Other (Friend, Caregiver):	Phone	×
Description of the information that may	be used or disclosed:	
 All verbal health information pertain respect to any physical, accident, illi I understand that if the person(s) that clinician covered by federal privacy by such person and will likely no lon If the person completing this authorize provide proof of authority to act on the 	ness, medical condition and any of t receives the information describe regulations, the information desc ager be protected by federal privac zation is the personal representati	ther health related information. ed herein is not a health care ribed here may be redisclosed by regulations.
Patient Signature:	Date:	
(If the patient signature is his/her mark, i	t must be witnessed by staff)	
Patients Representative:	Date:	
(Signature by Patients Representative mu	ust include a copy of documentation	on granting them authority to act on

patient's behalf) A copy of this form is as valid as the original. You may revoke this form in writing at any time.

(This form is valid for 1 year after date signed or until revoked)

Summit Nephrology Medical Group, Inc.

Welcome to our practice! Please take a few minutes and fill out the enclosed medical questionnaire prior to your appointment. By taking the time to provide us this information you will help our physicians to be more comprehensive and efficient during your evaluation. Please fill in information, circle appropriate diagnoses and symptoms and use the blank lines under each heading to provide information that you feel is relevant.

Past Medical History (Pleas	se circle):			
Diabetes	Hypertens	ion	Coro	nary Artery Disease
Stroke	High Chol	esterol	Blood	d Clots
Peripheral Vascular Diseas	e Lupus		Arth	ritis
Other:				
Please Explain:				
Surgical History (Include n				
1				
2				
3				
4				
5				
6				
Social History:				
Marital Status: Marri	ed Single	Divorced	Widowed	Other
Employment Status:				
Alcohol (Drinks per day an	d years used):			
Tobacco (Packs per day, nu Patient Name:				
;	Summit Nephrolog	y Health Histo	ry	1

Family History (Please include significant passing if relevant)	medical history for family members including age of their
Mother:	
Father:	
Children:	
Medication List (Please include dose per pi For example "Metoprolol 50 mg tabs, one	ill, number of pills taken and times per day. tablet two times a day":
1	
2	
3	
4	
6	
7	
8	
9	
11	
12	
14	
15	
Patient Name:	

Allergies (Medications or meaning) 1 2 3 4 Review of Systems List		list reaction also
	y history of the following: (Please c	heck <u>ves</u> or <u>no</u>)
General Y N □ Loss of Appetite □ Chills □ Sweats □ Fatigue □ Fever □ Unexpected weight change	Eyes Y N □ □ Vision loss/disturbance	Endo Y N □ □ Polydipsia (excessive drinking of water) □ □ Polyuria (excessive urinating)
HEENT/Allergy Y N □ □ Nosebleeds □ □ Allergy symptoms (sneezing, itching, runny nose)	Resp Y N □ Cough □ Shortness of breath □ Wheezing □ Apnea (not breathing when asleep) or sleep disordered breathing CV Y N □ Chest pain □ Leg swelling □ Palpitations	GU Y N □ □ Difficulty urinating □ □ Dysuria (painful urination) □ □ Flank pain □ □ Urinary frequency □ □ Hematuria (blood in urine) □ □ Urinary urgency
Dationt Name	Doto	

Summit Nephrology Health History

GI Y N □ Abdominal distention □ Abdominal pain □ Blood in stool □ Constipation □ Diarrhea □ Nausea □ Vomiting □ Acid reflux	Musculoskeletal Y N □ □ Arthralgias (pain in joint) □ □ Joint swelling □ □ Myalgias (pain in muscle) Heme Y N □ □ Bleeding or bruising	Neuro Y N □ □ Dizziness □ □ Light-headedness □ □ Numbness □ □ Seizures □ □ Tremors Psych Y N □ □ Confusion □ □ Decrease in concentration □ □ Anxiety		
Are there any other kidney-related symptoms you would like your doctor to know? Thank you for taking the time to give us this information. We at Summit Nephrology Medical Group look forward to working with you.				
Patient Signature:	Date of Birth:			
Print Name:	Date:			

Summit Nephrology Health History

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