NEPHROLOGY ASSOCIATES

Dear _____:

We would like to take this opportunity to welcome you to our practice. We value the trust you have extended to us by becoming one of our patients.

Your appointment is scheduled for _____, at_____ with Dr. _____ . Your visit will last 30-45 minutes. Please make sure your referring doctor is aware of your appointment date and time.

Please bring all insurance cards with you to your appointment.
☐ If checked, please drink water prior - we will request a urine sample.

Your appointment is at the following location:

☐ Nephrology Associates
1111 Delafield St., Ste 327
Waukesha, WI 53188
Southeast Entrance

☐ Community Memorial Hospital - Outpatient
W180 N8085 Town Hall Rd.
Menomonee Falls, WI 53051

☐ ProHealth Care Medical Ctr
Ruby Isle Clinic
2085 North Calhoun Road
Brookfield, WI 53005

☐ ProHealth Care-Sussex
N57W24950 N. Corporate Cir.
Sussex, WI 53089

☐ Fort Memorial Hospital
Outpatient Department
611 Sherman Ave. East
Fort Atkinson, WI 53538

☐ ProHealth Care-Oconomowoc
1185 Corporate Center Dr.
Oconomowoc, WI 53066

☐ ProHealth Care Medical Ctr
D. N. Greenwald Center
240 Maple Road
Mukwonago, WI 53149

☐ ProHealth Care-Watertown
109 Air Park Dr.
Watertown, WI 53094

☐ ProHealth Care-New Berlin
13900 W. National Ave.
New Berlin, WI 53151

☐ ProHealth Care-Muskego
S69 W15636 Janesville Rd.
Muskego, WI 53150

☐ ProHealth Care-Pewaukee
N16 W24131 Riverwood Dr.
Waukesha, WI 53188

In order to make your first appointment easier, we would appreciate your taking a few minutes at home to fill out the enclosed forms. Please bring the completed forms with you to your appointment. If you have any questions about the forms, please call our office, and our staff will be happy to assist you.

HEALTH INSURANCE EXCHANGE PATIENTS: If you participated in the Health Insurance Exchange to get your coverage, please contact our billing department at **262-696-0308** at least **10 days before your appointment** to ensure that an authorization is in place and that your visit will be covered.

MANAGED CARE PATIENTS (HMO, PPO, POS, HCN, etc.): If you are currently enrolled in a managed care policy, it is **your** responsibility to make sure the provider you have chosen is listed in your policy coverage. You may call your company to ask them. Our physicians are not "primary care providers," therefore, if a **referral** is necessary for coverage, it is **your** responsibility to contact your primary care physician prior to your appointment to obtain permission to see our physicians. If you arrive for your appointment without a referral, this may delay your visit and/or cause you to be responsibile for the bill. Any co-pays are due at the time of your visit.

PATIENTS WITHOUT INSURANCE: Your health care needs are important to us! We will be happy to set up a payment plan on the date of your visit, if necessary.

T-19/MEDICAID PATIENTS: It is necessary that you have a primary care physician to obtain a referral form prior to your appointment with us. Please have your referral and your T-19 card with you for your visit.

Thank you for your time and we look forward to meeting you.

OVERVIEW

THE MEDICAL ASSOCIATION CONCEPT

Although each physician in our office has his own patients, we are a partnership. This means that one of the physicians in our office is always available to meet your medical needs, even if it is not your personal physician. They each have certain designated times "on" and "off" call, and answer weekend calls on a rotating basis. We will always have one of our physicians available 24 hours a day, 7 days a week to handle urgent problems.

As consulting physicians, we can assure you that after each visit with us, a report of that visit is sent to your primary or referring physician, whomever you designate. We are available to them, also, for any questions or concerns.

LAB AND DIAGNOSTIC TESTS

You will often be asked to have blood, urine, or other diagnostic tests done prior to your visit with the physician. The office staff will also note where you intend to do those tests, so that they are able to obtain the results prior to your next appointment.

Whenever possible, our office staff will assist you in scheduling any diagnostic testing. The results of any testing will be discussed with you at your appointment following those tests. Those results will be included in the report of your visit to your primary/referring physician.

PRESCRIPTIONS/REFILLS

We request that you bring a list of your current medications with you for each visit. It is recommended that you request any new prescriptions, refills, etc., at your visit. If you find that refills are needed between visits, please have your pharmacy call us, and refills will be authorized through your next scheduled appointment. If appointments are missed, we will be unable to continue refilling medications.

NEPHROLOGY ASSOCIATES

PLEASE PRINT

Please indicate which doctor you will be seeing:

____ Adel Korkor, MD ____ Logan Elangovan, MD ____ Mark Carey, MD ____ Imran Sajjad, MD

REFERRING PHYSICIAN: _____ _____

Why have you been referred to us: _____

PATIENT INFORMATION

PATIENT NAME: _____
Last First Middle Initial

ADDRESS: _____
City State ZIP

TELEPHONE NO.: (_ _ _) _ _ _ - _ _ _ _ (HOME) (_ _ _) _ _ _ - _ _ _ _ (WORK)

DATE OF BIRTH: (month/day/year) _ _ / _ _ / _ _ _ _ CURRENT AGE: _____

MARITAL STATUS: Single Married Divorced Widowed (Circle one) SOC. SEC. #: _ _ _ - _ _ - _ _ _ _

SPOUSE NAME: _____ _____
Last First Date of B irth

ADDRESS (If different from above) _____
City State ZIP

EMPLOYER NAME: _____ Retired: _____(X)

ADDRESS: _____
City State ZIP

OCCUPATION: _____

EMERGENCY CONTAC T: _____ RELATIONSHIP: _____

HOME PHONE: (_ _ _) _ _ _ - _ _ _ _ WORK PHONE: (_ _ _) _ _ _ - _ _ _ _

PREFERRED PHARMACY: _____ PHONE #: _____-_____-_____

BILLING INFORMATION (Responsible Party, if different from above)

NAME: _____ RELATIONSHIP: _____
Last First Middle Initial

ADDRESS: _____
City State ZIP

TELEPHONE NO.: (_ _ _) _ _ _ - _ _ _ _ (HOME) (_ _ _) _ _ _ - _ _ _ _ (WORK)

SOCIAL SECURITY NO.: _ _ _ - _ _ - _ _ _ _ DATE OF BIRTH: _ _ / _ _ / _ _ _ _

EMPLOYER NAME: _____

EMPLOYER ADDRESS: _____
City State ZIP

TELEPHONE NO.: (_ _ _) _ _ _ - _ _ _ _ CONTACT: _____

Please check any items that have applied to you. Please provide details of checked items in the space provided beneath each section.

____ Weight gain	____ Tire easily	
____ Weight loss	____ Persistent or recurring fevers	

____ Decrease in hearing	____ Ringing in ears	____ Sore throat
____ Earaches	____ Nosebleeds	____ Dental problems

____ Frequent colds	____ Wheezing	____ Blood or other mucous when coughing
____ Persistent cough	____ Shortness of breath	

____ Pain/burning w/ urination	____ Odor in urine	____ Decreased amount of urine
____ Blood in urine	____ Frequent urination	____ Leaking of urine
		____ Lack of sex drive

____ Rash	____ Non-healing cuts
____ Itchy/dry areas	

____ Depression	____ Sleeplessness
____ Anxiety	

____ Sweating while sleeping	____ Swollen lymph glands (or neck)
____ Excessive daytime sleepiness	____ Very loud snoring

____ Double vision	____ Blurred vision	____ Eye pain or itching

____ Racing heart or skipped beats	____ Swollen ankles/feet	Shortness of breath with:
____ Chest pain or tightness	____ Blood clots	____ rest ____ exertion ____ laying down

____ Poor appetite	____ Nausea or vomiting	____ Constipation
____ Frequent heartburn	____ Rectal bleeding/bloody bowel movements	____ Diarrhea
		____ Abdominal pain

____ Painful, stiff or swollen joints	____ Arm weakness	____ Persistent or recurrent back pain
____ Leg cramps	____ Leg weakness	

____ Dizzy spells	____ Recurrent headaches	____ Seizures
____ Memory loss	____ Numb or tingling areas	

____ Thyroid problems	____ Diabetes

____ Allergies/hay fever

If you have any concerns or symptoms not previously listed, please include them here:

(Please continue on back of sheet, if needed)

Are you taking any of the following medicines:

_____ Advil / Motrin / Ibuprofen

_____ Aleve / Naproxen

_____ Prednisone or steroids

_____ Vioxx, Celebrex

_____ any arthritis pain formula medicine

CURRENT MEDICATIONS:
Include all prescription medications—even those taken only as needed and also vitamins and mineral supplements. We need to review this list each time you see your physician.

_____

_____

_____

Medication Allergies: _____

_____

Past Surgeries (include year done):

_____ _____

_____ _____

_____ _____

Have you ever been diagnosed with any of the following (if so, when?):

___/___/_____ Congestive heart failure

___/___/_____ High blood pressure/hypertension

___/___/_____ Diabetes
Age of onset? _____ yrs.

___/___/_____ Recurrent bladder infections

___/___/_____ Any sort of kidney failure

___/___/_____ Any other kidney problem

___/___/_____ Kidney stones
How many? _____

Any other previous medical problems? (Include year of diagnosis):

_____ _____

_____ _____

_____ _____

Family History (List any medical problems (especially kidney) family members have or had. If deceased, please include age at death and problem that caused death):

Mother: _____

Father: _____

Brothers: _____

_____

Sisters: _____

_____

Children: _____

_____

Do you smoke? _____ How many per day? _____

Age you began smoking? _____ If quit, date of cessation: _____

Do you drink alcohol? _____ If so, what and how often? _____

Women only:
Last menstrual period: _____ Menopause at what age? _____

No. of pregnancies: _____ No. of deliveries: _____ No. of children: _____
Are you taking hormones now? _____ If not now, have you had hormonal replacement in the past? _____ If so, what and why was it stopped?

_____

Bone Patients only:
Have you had any fractures? _____ If so, where, when and how?

_____

_____

_____

Have you had any height loss? _____ If so, how much? _____

All Patients:
Do you do any regular exercise? What, for how long, and how often?

_____

Are you on any special diet? If so, what?

_____

Please list daily/weekly intake amount of the following foods: (circle either day or week)

Milk (Whole, 2%, 1% or Skim) _____ cup/oz. per day / week
Cheese _____ cup/oz. per day / week
Ice cream / Yogurt _____ cup/oz. per day / week
Meat (including fish and poultry) _____ cup/oz. per day / week
Vegetables _____ cup/oz. per day / week
Fruit _____ cup/oz. per day / week
Coffee (regular or decaf.) _____ cup/oz. per day / week
Soft drinks (specify usual brand) _____ cup/oz. per day / week
Water _____ cup/oz. per day / week

How much stress do you feel is in your life at this time? (circle one)

None Too much
1 2 3 4 5

Thank you for taking the time
to carefully record this important information.

IT IS THE POLICY OF NEPHROLOGY ASSOCIATES OF WAUKESHA, S.C. THAT COPAYS ARE DUE AT THE TIME OF SERVICE.

I AUTHORIZE THE PHYSICIAN TO RELEASE ANY INFORMATION ACQUIRED DURING THE COURSE OF MY EXAMINATION AND/OR TREATMENT TO SPECIFIC PHYSICIANS AND/OR MY INSURANCE COMPANY. I PERMIT PAYMENT DIRECTLY TO PURITY DIALYSIS CENTERS AND/OR NEPHROLOGY ASSOCIATES OF WAUKESHA, S.C. FOR ANY SERVICES RENDERED. I RECOGNIZE AND ACCEPT RESPONSIBILITY FOR ANY BALANCE REMAINING AFTER PAYMENT OF SUCH BENEFITS. A PHOTOSTAT COPY OF THIS FORM IS AS VALID AS THE ORIGINAL.

SIGNED: _____ DATE: _____