



3525 Ensign Road N.E., Suite K ■ Olympia, Washington 98506 ■ (360) 413-8121 ■ Fax (360) 413-8865

### Patient Information Sheet

(Please complete all items – N/A if not applicable)

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Physical Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ Social Security #: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Sex:  M  F

E-mail: \_\_\_\_\_

Spouse Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Employer Name & Address: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_ May we contact if necessary?  Y  N Social Security #: \_\_\_\_\_

#### Emergency Contacts (OTHER THAN SPOUSE):

Name & Relation: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Address: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Name & Relation: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Address: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Which physician are you seeing here?    Nguyen   Thaler   Burtner   Sivakumar   Dhondup  

Who is your family physician? \_\_\_\_\_

Did a different physician refer you here?    Yes        No        If so, who? \_\_\_\_\_

Do you have insurance coverage?        Yes        No\*

\*Memorial Nephrology is dedicated to providing compassionate medical care to all members of the community regardless of their ability to pay for services. This practice offers a financial hardship program for which you may be eligible. Please inquire at the front desk to obtain the appropriate forms and information.

**Primary Insurance Coverage:** \_\_\_\_\_

Subscriber: \_\_\_\_\_ Relationship: \_\_\_\_\_

Identification Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Does this insurance require a referral?    Yes        No        If yes, referral #: \_\_\_\_\_

Co-Pay Amount: \$ \_\_\_\_\_ Annual Deductible: \$ \_\_\_\_\_

**Secondary Insurance Coverage:** \_\_\_\_\_

Subscriber: \_\_\_\_\_ Relationship: \_\_\_\_\_

Identification Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Does this insurance require a referral?    Yes        No        If yes, referral #: \_\_\_\_\_

Co-Pay Amount: \$ \_\_\_\_\_ Annual Deductible: \$ \_\_\_\_\_

(All of the above information must be completed in addition to copies of your insurance cards)

\* \* \* \* \*

I hereby authorize Memorial Nephrology Associates to release any medical information which may be required to process claims for payment of medical services through my insurance carrier, prepaid medical plan or government agency. I acknowledge that I am financially responsible for all charges. If it becomes necessary to effect collections of any amount owed on this or subsequent visits the undersigned agrees to pay for all costs and expenses, including reasonable attorney fees.

\_\_\_\_\_  
Patient or legally authorized individual signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to patient if signed on behalf of the patient.



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### Patient Contact Information

Please list the family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis:

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Please list the family members or significant others, if any, whom we may inform about your medical condition **ONLY IN AN EMERGENCY**:

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Please print the address of where you would like your billing statements and/or correspondence from our office to be sent **IF OTHER THAN YOUR HOME**.

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Please print the phone number, if any, where you want to receive calls about your appointments, lab and x-ray results, or other health care information if other than your home phone number: (\_\_\_\_) \_\_\_\_\_

Can confidential messages (i.e. appointments reminders) be left on your **home** answering machine or voicemail?  Yes  No

If you don't have voicemail, can a confidential message be left with whoever answers your **home** phone?  Yes  No  
If no, whom specifically may we leave a message with?

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May we contact you at work?  Yes  No

If yes, can confidential messages be left on your **work** answering machine or voicemail?  Yes  No

If you don't have voicemail, can a confidential message be left with whoever answers your **work** phone?  Yes  No  
If no, whom specifically may we leave a message with?

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**Patient Name:** \_\_\_\_\_  
Last Name First Name Middle Initial

\_\_\_\_\_  
Patient or legally authorized individual signature Date

\_\_\_\_\_  
Relationship to patient if signed on behalf of the patient.



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### Consent for Use and Disclosure of Health Care Information

Patient Name: \_\_\_\_\_

Social Security #: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Previous Name: \_\_\_\_\_

My health information is a private matter. Memorial Nephrology Associates, PLLC has a form that can tell me how Memorial Nephrology Associates, PLLC handles my health information. This form is called "Notice of Privacy Practices". If I ask, Memorial Nephrology Associates, PLLC will be happy to provide me with the most current "Notice" before I sign this consent. Memorial Nephrology Associates, PLLC may update this "Notice" at any time. If I ask, I will get a copy of the most current "Notice". I agree that Memorial Nephrology Associates, PLLC may use and disclose my health information to help treat me. I agree that Memorial Nephrology Associates, PLLC may use or disclose my information for billing and payment. I also agree to uses and disclosures of my health information to take care of other health care operations. In general, there are no other uses or disclosures of my health information will occur unless I tell Memorial Nephrology Associates, PLLC it's okay. Sometimes the law may allow release of information without my permission. These situations are unusual. One example would be if a patient threatened to hurt someone. I can ask Memorial Nephrology Associates, PLLC to further limit the use or disclosure of my health information. Memorial Nephrology Associates PLLC is not required to agree to my request. If Memorial Nephrology Associates, PLLC agrees to any part of my request, Memorial Nephrology Associates, PLLC would have to follow the agreed limits. I may cancel this consent at any time, by doing one of the following:

- Signing and dating a revocation form. I may get this form from Memorial Nephrology Associates, PLLC; or
- Writing, signing, and dating a letter to Memorial Nephrology Associates, PLLC. The letter must say I cancel my consent to authorize the use and disclosure of my health information for treatment, payment and health care operations.

If I cancel this consent:

- It will be effective except for actions already taken based upon the Consent; and
- Memorial Nephrology Associates, PLLC will not have to provide any more health care services to me.

I have been given the chance to read a current copy of Memorial Nephrology Associates, PLLC's "Notice of Privacy Practices". I agree to allow Memorial Nephrology Associates, PLLC to use and disclose my health information to carry out treatment, payment, and health care operations.

\_\_\_\_\_  
Patient or legally authorized individual signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to patient if signed on behalf of the patient.



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Please complete this questionnaire so that we can update your medical history.

Patient Name: \_\_\_\_\_  
Last Name First Name Middle Initial

Date of Birth: \_\_\_\_\_ Primary Physician: \_\_\_\_\_ Phone #: \_\_\_\_\_

Preferred Pharmacy: \_\_\_\_\_

**YOUR MEDICATIONS/VITAMINS/SUPPLEMENTS** (Please include strength & frequency)

PLEASE BRING ALL MEDICATION BOTTLES TO YOUR APPOINTMENT

Two columns of horizontal lines for listing medications, vitamins, and supplements.

**MEDICATION ALLERGIES** (Please include reactions)

Two columns of horizontal lines for listing medication allergies and reactions.

**YOUR PREVIOUS MEDICAL HISTORY**

Have you had any of the following?

**RISK FACTORS**

- Diabetes
- High Blood Pressure
- High Cholesterol
- Transfusions

**HEART HISTORY**

- Coronary Angioplasty/Stenting Date(s) \_\_\_\_\_
- Congestive Heart Failure Date(s) \_\_\_\_\_
- Heart Attack Date(s) \_\_\_\_\_
- Heart Surgery Date(s) \_\_\_\_\_
- Rheumatic Fever Date(s) \_\_\_\_\_

**KIDNEY/UROLOGIC HISTORY**

- Prostate Surgery
- Kidney Stones
- Urinary Tract Infections
- Bladder/Prostate/Kidney Cancer
- Dialysis

**FAMILY HISTORY** Please complete the following questions:

**MARITAL STATUS**

- Divorced
- Married
- Separated
- Single
- Widowed
- Significant other

**CHILDREN**

- \_\_\_\_\_ Sons
- \_\_\_\_\_ Daughters
- \_\_\_\_\_ Stepsons
- \_\_\_\_\_ Stepdaughters

**DIABETES?**

- Father
- Mother
- Brother
- Sister

TYPE: \_\_\_\_\_

**CANCER?**

- Father
- Mother
- Brother
- Sister

Please list all of your other illnesses & surgeries:

**ILLNESSES**

**DATE OF ONSET**

|       |       |
|-------|-------|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

**SURGERIES**

**DATE**

|       |       |
|-------|-------|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

**HEART DISEASE/HIGH BP**

- Father
- Mother
- Brother
- Sister

TYPE: \_\_\_\_\_

**KIDNEY PROBLEMS?**

- Father
- Mother
- Brother
- Sister

TYPE: \_\_\_\_\_

**OTHER FAMILY ILLNESSES:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

TYPE: \_\_\_\_\_

**SOCIAL HISTORY** Please complete the following questions:

**EMPLOYMENT**

- I am employed. Job & Location \_\_\_\_\_
- Previous job. Job & Location \_\_\_\_\_
- I am a student. Where? \_\_\_\_\_
- I am disabled.  I am retired.  I am unemployed

**LIVING SITUATION (Please check all that apply)**

- I live alone.  I live with my spouse.
- I live with my children.  I live with a care giver.
- I live in a nursing facility/adult care facility.
- I live \_\_\_\_\_.

**TRANSPORTATION**

- I drive.  I rely on public transportation.
- I rely on my family for transportation.

**RECENT HEALTH** Do you have:

**GENERAL**

- Chills
- Fatigue
- Fevers
- Sweats
- Other \_\_\_\_\_

**GASTRONINTESTINAL**

- Indigestion
- Nausea
- Vomiting
- Other \_\_\_\_\_

**HEART**

- Chest Pain
- Chest Pressure
- Palpitations

**HEAD/ENT**

- Headaches
- Nose Bleeds
- Ear Ache
- Eye Pain
- Blurry Vision
- Double Vision

**LUNGS**

- Cough
- Short of Breath
- Wheezing
- Other \_\_\_\_\_

**ARTHRITIS**

- Hand/Wrist
- Knee/Feet

**SMOKING HABITS**

- I smoke \_\_\_packs/day. How long? \_\_\_years.
- I smoked \_\_\_packs/day. How long? \_\_\_years.
- When did you stop? \_\_\_months/years ago.
- I never smoked.

**ALCOHOL HABITS**

- I drink alcohol. How much beer? \_\_\_beers/day.
- How much liquor? \_\_\_glasses/day.
- How much wine? \_\_\_glasses/day.
- I used to drink  I'm a recovering alcoholic.
- I never drink.  I used to drink socially.

**DRUG USE**

- History of IV drugs.  History of other drugs.

**SKIN**

- Rashes
- Itching
- Other \_\_\_\_\_

**GENITOURINARY**

- Urinary Infections/  
Pain w/ Urine
- Incontinence
- Trouble Voiding
- Blood in Urine
- Frequent Urinating
- Other \_\_\_\_\_

**NEUROLOGICAL**

- Convulsions/Seizures
- Memory Loss

**MUSCULAR**

- Muscle Pain
- Muscle Weakness
- Other \_\_\_\_\_

**PSYCHIATRIC**

- Anxiety Disorder
- Depression
- Other \_\_\_\_\_

**OTHER**

- Intolerance to Heat
- Intolerance to Cold
- Anemia
- Bleeding
- Sweats
- Other \_\_\_\_\_

Light Headedness                       Low Back                       Tremors                      Your height \_\_\_\_\_  
 Other \_\_\_\_\_                       Other \_\_\_\_\_                       Other \_\_\_\_\_                      Your weight \_\_\_\_\_

**Patient Name:** \_\_\_\_\_  
Last Name                      First Name                      Middle Initial

**FOR MEDICAL PURPOSES ONLY PLEASE SELECT FROM THE FOLLOWING**

This information is being requested in accordance with federal regulations. We are required to collect the following information to satisfactorily participate in the meaningful use program. Thank you for your cooperation.

**RACE:**

- American Indian/Alaskan Native                       Asian                       Black/African American  
 Native Hawaiian/Pacific Islander                       White/Caucasian                       Other \_\_\_\_\_  
 Declined

**Ethnicity (select one):** Hispanic of Latino ethnicity refers to individuals who trace their origin to Mexico, Puerto Rico, Cuba, Central or South America or other Spanish cultures.

- Hispanic or Latino                       Not Hispanic or Latino                       Declined

**Language(s):** Please indicate only languages you are fluent in when communicating about medical care.

- I speak English only.  
 I speak \_\_\_\_\_.  
 I speak \_\_\_\_\_.  
 I speak \_\_\_\_\_.

\_\_\_\_\_  
Patient or legally authorized individual signature

\_\_\_\_\_  
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## **Patient Code of Conduct**

To provide a safe and healthy environment for patients and their family members, visitors and staff, we expect visitors, patients and accompanying family members to refrain from unacceptable behaviors that are disruptive or pose a threat to the rights or safety of other patients, visitors and staff.

### **The Following Behaviors are Prohibited:**

- Possession of firearms or any weapon
- Physical assault, arson or inflicting bodily harm
- Throwing objects
- Making verbal threats to harm another individual or destroy property
- Intentionally damaging equipment or property
- Making menacing gestures
- Making suggestive or lewd comments or gestures
- Attempting to intimidate or harass other individuals
- Making harassing, offensive, or intimidating statement, or threats of violence through phone calls, letters, email, or other forms of written, verbal, or electronic communications
- Racial or cultural slurs or other derogatory remarks associated with but not limited to race, language, or sexuality.

If you are subject to any of these behaviors or witness inappropriate behavior, please report to any staff member. Violators are subject to removal from the facility and risk immediate discharge from the Practice.

I have read and understand the patient code of conduct.

Printed Name: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_

# Do you use the Internet?

Would you like to be able to send your doctor's office a quick message after hours or take a look at your lab results on-line? How about checking to see when your next appointment is or requesting a prescription refill? Great! Now you can . . .

Memorial Nephrology Associates is offering a *FREE* secure on-line service linking you to our healthcare team using MYCHART. Use your computer or use your smartphone, it's a quick and easy way for you to communicate with our office staff or look-up information any time of day.

## What you will be able to do:

- View current and historical lab results
- Securely message office staff
- View medications/allergies and request prescription refills
- Request and/or view your appointment information
- Print and review practice forms and handouts
- Monitor anticoagulation graphing and dosing
- Review problem list details
- Receive lab/radiology orders, clinical notes, etc. from provider office
- Immediately receive follow-up letters electronically
- Receive appointment reminder messages

**Please complete the information below and give this to your nurse to get access today!**

Print Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

## Select your Provider:

|                          |
|--------------------------|
| <input type="checkbox"/> |
| <input type="checkbox"/> |
| <input type="checkbox"/> |

Dr. Burtner

Dr. Dhondup

|                          |
|--------------------------|
| <input type="checkbox"/> |
| <input type="checkbox"/> |
| <input type="checkbox"/> |

Dr. Nguyen

Dr. Sivakumar

Dr. Thaler

## Would you like to receive this FREE service?

\_\_\_\_\_ Sign me up.      \_\_\_\_\_ I do not have Internet or an e-mail address.

E-Mail Address: \_\_\_\_\_

# Memorial Nephrology Associates, PLLC

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## Located in the Medical Resource Center

### From the south:

1. Take I-5 North
2. Take exit #107 (Pacific Ave), merge right onto Pacific Ave.
3. Turn left on Lilly Rd
4. Turn left at the 3rd stoplight (Ensign Rd)
5. Take first left into the parking lot.

### From the north:

1. Take I-5 South
2. Take exit #109 (Martin Way)
3. Turn right onto Martin Way
4. Turn Right on Lilly Rd

5. Turn left at the 1<sup>st</sup> stoplight (Ensign Rd)
6. Take first left into the parking lot.