Memorial
Nephrology
Associates, PLLC

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 ☐Batarseh ☐ Sivakumar ☐ Dhondup ☐Shah

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:

_____

_____

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

_____

_____

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.**

_____

_____

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?

_____

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?

_____

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.

_____ _____

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_____

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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

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

MEDICATION ALLERGIES (Please include reactions)

_____
_____
_____
_____
_____
_____
_____

COVID VACCINE INFO:

☐Vaccinated ☐Not Vaccinated
☐Moderna Date(s) _____ Date(s) _____
☐Pfizer Date(s) _____ Date(s) _____
☐Johnson & Johnson
Date(s) _____ Date(s) _____
☐Booster Date(s) _____ Date(s) _____

_____

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

Please list all of your other illnesses & surgeries:

ILLNESSES **DATE OF ONSET**

_____

_____

_____

_____

_____

_____

_____

SURGERIES **DATE**

_____

_____

_____

_____

_____

_____

_____

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

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.

SMOKING HABITS

☐I smoke ___packs/day. How long? ___years.

☐I smoked ___packs/day. How long? ___years.

When did you stop? ____months/years ago.

☐I smokeless tobacco. ☐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.

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

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 <u>fluent</u> in when communicating about medical care.

☐I speak English only.

☐I speak _____.

☐I speak _____.

☐I speak _____.

_____ _____

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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:

☐	Dr. Batarseh	☐	Dr. Nguyen
☐	Dr. Dhondup	☐	Dr. Sivakumar
☐	Dr. Shah	☐	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: _____

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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 1st stoplight (Ensign Rd)
6. Take first left into the parking lot.