KIDNEY SPECIALISTS
OF SOUTHERN NEVADA

Dear Patient:

As a part of the new patient process, we are asking you to complete and sign the enclosed patient history forms. Please also bring a list of all the medications that you are taking.

Listed below is the information regarding your upcoming appointment:

DR/ APRN/ PA: ____

Date: ____

Arrival Time: ____ AM/ PM

Appointment Time: ___________________________________ AM/ PM

Address: ____

Please bring the completed forms to your upcoming appointment.

Kidney Specialists of Southern Nevada would like to thank you for your assistance and cooperation in completing the enclosed forms.

Sincerely,

Kidney Specialists of Southern Nevada

KIDNEY SPECIALISTS
OF SOUTHERN NEVADA

DATE	PLEASE ENTER THE NAME OF THE DOCTOR YOU ARE SEEING TODAY	☐ **New Patient** ☐ **Established Patient**

PATIENT INFORMATION

PATIENT NAME (LAST)	(FIRST)	(M.I)	SSN:

HOME PHONE	SEX	DATE OF BIRTH	AGE	MARITAL STATUS ☐SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐SEPERATED	RACE ☐CAUCASIAN ☐HISPANIC ☐ ASIAN ☐ AFRICAN AMERICAN ☐OTHER

ADDRESS	APT./SPACE/UNIT
CITY / STATE	ZIP

CITY	STATE	ZIP
PATIENT'S EMPLOYER (Guarantor if patient is a minor or unemployed)	OCCUPATION	
EMPLOYER'S ADDRESS		WORK PHONE
CITY	STATE	ZIP

GUARANTOR INFORMATION

GUARANTOR NAME (LAST) (FIRST) (M.I.)	SSN	HOME PHONE

GUARANTOR ADDRESS	CITY	STATE	ZIP
GUARANTOR EMPLOYER	OCCUPATION	HOME PHONE	
GUARANTOR EMPLOYER ADDRESS	CITY	STATE	ZIP

M.D	REASON FOR VISIT	PRIMARY PHYSICIAN	HOW DID YOU HEAR ABOUT OUR OFFICE?

EMERGENCY	WHO TO NOTIFY IN CASE OF AN EMERGENCY	PHONE	RELATIONSHIP	
	ADDRESS	CITY	STATE	ZIP

INSURANCE INFORMATION (Please have Patient Representative copy your insurance cards)

PRIMARY INSURANCE CO.			PHONE
ADDRESS	CITY	STATE	ZIP
POLICY HOLDER NAME	DATE OF BIRTH		SSN
RELATIONSHIP TO PATIENT	POLICY HOLDERS EMPLOYER		
POLICY #	GROUP #	EFFECTIVE DATE	

SECONDARY INSURANCE CO.			PHONE
ADDRESS	CITY	STATE	ZIP
POLICY HOLDER NAME	DATE OF BIRTH		SSN
RELATIONSHIP TO PATIENT	POLICY HOLDERS EMPLOYER		
POLICY #	GROUP #	EFFECTIVE DATE	

The above information is complete and correct. I authorize treatment of the above-named patient. I hereby authorize release of information necessary to file a claim with my insurance company and I assign benefits otherwise payable to me to the doctor or group indicated on the claim. All professional services rendered are charged to the patient. The patient is responsible for all fees, regardless of insurance coverage. In the event of collection proceedings due to lack of payment on my part, I agree to pay any and all collection fees that may be added to my account in order to recover monies due to the doctor. A copy of the signature is as valid as the original.

______________________ Name of Patient/ Patient Representative

______________________ Signature of Patient/ Patient Representative

______________________ Date

KIDNEY SPECIALISTS
OF SOUTHERN NEVADA

Name: ______________________________

Date: ______________________

Medication List

Medication	**Dosage**	**Directions**

Allergies:	

Revised 1/31/2020

KIDNEY SPECIALISTS OF SOUTHERN NEVADA

CANCELLATION AND NO SHOW POLICY

Effective November 2, 2015

We understand that situations arise in which you must cancel your appointment. It is therefore requested that if you must cancel your appointment you provide more than 48 hours notice. This will enable us to schedule a patient who is waiting for an appointment. With cancellations made with less than a 48 hour notice, we are unable to offer that slot to another patient. Patients who cancel three (3) or more times in a 12 month period may be dismissed from the practice & thus they will be denied any future appointments.

Office appointments which are cancelled with less than 48 hours notification will be subject to a **$25.00** cancellation fee.

Patients who do not show up for their appointment without a call to cancel an appointment will be considered a **NO SHOW**. Patients who No-Show three (3) or more times in a 12 month period may be dismissed from the practice & thus they will be denied any future appointments. Patient will also be subject to a **$25.00** fee for the No Show.

The cancellation and no show fees are the sole responsibility of the patient and must be paid in full before the patient's next appointment. These will not be billed to or paid by your insurance(s).

We understand that special unavoidable circumstances may cause you to cancel within 48 hours. Fees in this instance may be waived, but only with management approval.

Our practice firmly believes that a good physician/patient relationship is based upon understanding and good communication. Questions about cancellation and no show fees should be directed to the billing department (702-551-9070).

Please sign that you have read & understand our cancellation and no show policy.

____ **Date of birth:**______________

Patient Name (Please Print)

____ ______________________

Signature of Patient or Patient Representative **Date**

Rev 07/29/15

AYOOLA ADEKILE, M.D.
TAURINO AVELAR, M.D.
MARVIN J. BERNSTEIN, M.D.
ADIN BOLDUR, M.D.
VENUGOPAL BOTLA, M.D.
JAY K. CHU, M.D.
DINA CORBIN, M.D.
BILAL IQBAL, M.D.
GAURAV JAIN, M.D.
BINDU KHANNA, M.D.
JENNIFER KUMAR, M.D.
LARRY M. LEHRNER, M.D.
MARC LEISEROWITZ, M.D.
THOMAS LIM, M.D.
ROBERT W. MERRELL, M.D.
SEYEDQUMARS MIRFENDERESKI, M.D.
DEEPAK NANDIKANTI, M.D.
SHADI NIJIM, M.D.
CHIDI OKAFOR, M.D.
NEVILLE POKROY, M.D.
RAO PRASAD, M.D.
RIZWAN QAZI, M.D.

KIDNEY SPECIALISTS
OF SOUTHERN NEVADA

RAMCHAND RANAI, M.D.
PHILLIP RIBEIRO, M.D.
CRISTY ROBERTSON, M.D.
KAMRON SALEEM, M.D.
ZVI SELA, M.D.
SYED SHAH, M.D.
VIPUL SHAH, M.D.
RAJ P. SINGH, M.D.
NAUMAN TAHIR, M.D.
VIVEK VEERAPANENI, M.D.
MARK VISHNEPOLSKY, M.D.
VINCENT YANG, M.D.
KEVIN YU, D.O.
MYRA BARLAAN, APRN
ZVIA BEN-REY, APRN
NERISSA BONINA, APRN
VALERIE CHANG, PA-C
MELISSA HANSEN, APRN
NATHAN HUGG, APRN
CATHERINE LORENTZ, APRN
LA DONNA MILLS, APRN
LEIGHA SCHAFER, APRN

I, ____, give authorization to Kidney Specialists of Southern Nevada to obtain my picture to be kept on file within their Electronic Medical Records System for the purposes of in assistance preventing insurance fraud.

____ ____________________________

Patient Signature Date

____

Email Address

Please list all of your current Pharmacies with address and/ or phone numbers below

____

____

____

500 So. Rancho Drive, Suite 12, Las Vegas, NV 89106-4849 • 653 N. Town Center Drive, Bldg. 2, Suite 70, Las Vegas, NV 89144 • 8775 Deer Springs Way, Las Vegas, NV 89149
100 N. Green Valley Pkwy., Suite 310, Henderson, NV 89074 • 9280 W. Sunset Road, Suite 438, Las Vegas, NV 89148 • 7316 W. Cheyenne Ave., Las Vegas, NV 89129
2065 North Las Vegas Blvd., N. Las Vegas, NV 89030 • 330 S. Lola Lane, Suite 200, Pahrump Nevada 89048

Telephone (702) 877-1887 • FAX (702) 877-4536
www.ksosn.com

KIDNEY SPECIALISTS
OF SOUTHERN NEVADA

CONSENT TO USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

USE AND DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION
Your protected health information will be used by Kidney Specialists of Southern Nevada or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of the practice.

NOTICE OF PRIVACY PRACTICES
You should review the Notice of Privacy Practices for a more complete description of how your protected health information may be used or disclosed. You may review the notice prior to signing this consent.

REQUESTING A RESTIRCTION ON THE USE OR DISCLOSURE OF YOUR INFORMATION
You may request a restriction on the use or disclosure of your protected health information. Kidney Specialists of Southern Nevada may or may not agree to restrict the use or disclosure of your protected health information. If Kidney Specialists of Southern Nevada agrees to your request, the restriction will be binding on the practice. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

REVOCATION OF CONSENT
You may revoke this consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

RESERVATION OF RIGHT TO CHANGE PRIVACY PRACTICES
Kidney Specialists of Southern Nevada reserves the right to modify the privacy practices outlined in the notice.

AUTHORIZED PERSONS TO RECEIVE DISCLOSED INFORMATION:

Name: ____

Relationship to Patient: ____

Name: ____

Relationship to patient: ____

SIGNATURE
I have reviewed this consent form and give my permission to Kidney Specialists of Southern Nevada to use and disclose my health information in accordance with it.

____ ______________________
Name of Patient Date

____
Signature of Patient/ Patient Representative/ Relationship to Patient

Revised 1/31/2020

KIDNEY SPECIALISTS OF SOUTHERN NEVADA

AUTHORIZATION TO RELEASE/ DISCLOSE HEALTH INFORMATION

DATE	HEALTH RECORD NUMBER	PATIENT'S DOB
PATIENT'S NAME (Last)	(First)	(M.I)

I ________________________________ , authorize the use and disclosure of the above name individual's health information described below. The following individuals or organizations have authorization to make disclosure of my health information records.

ORGANIZATION'S NAME		
ADDRESS		
CITY	STATE	ZIP

RELEASE INFORMATION TO

ORGANIZATION'S NAME	
ADDRESS	
PHONE NUMBER	FAX NUMBER

DATE RANGE OF RECORDS TO BE RELEASED: From: ______________ , 20 ______ to: ______________ , 20 ______

I WOULD LIKE A COPY OF MY RECORDS ON ☐ Paper @ $0.60 per page ☐ CD

☐ Entire Health Records	☐ Transplant Information	☐ X-Ray Results	☐ Financial Information
☐ History & Physical	☐ Biopsy Results	☐ Lab Results	☐ Other: ____________.
☐ Prescription List	☐ Hospital Records	☐ Progress Notes	

This authorization to release health information expires on: ______________, 20 _____ . If no date is provided the Authorization will expire one year from the signature date. I understand that the information in my health records may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental services, and the treatment for alcohol and drug abuse. I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present my written revocation to the health information privacy officer. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when it provides my insurer with the right to consent a claim under my insurance policy unless otherwise revoked. **This authorization will expire on the following date or condition: ________________, 20 ________. If I fail to specify an expiration date, event or condition this authorization will expire one year from the signature date below.** If I have any questions regarding this disclosure of my health information, I can contact the privacy officer at 702-877-1887.

____ ________________

Patient Signature or Legal Representative Date

____ ________________

If Signed by Legal Representative, Relationship to Patient Date

Your Rights as a Patient

As a patient, you have the right to:

1. Receive equitable, unbiased, considerate, and respectful care and to be treated with courtesy and dignity.
2. Receive equal treatment at all times and under all circumstances, regardless of race, color, religion, national origin, sex, age, marital status, personal appearance, sexual orientation, veteran status, family responsibilities, disability, infectious disease, matriculation, political affiliation, source of income or place of residence or business.
3. Receive considerate and respectful care in a clean and safe environment.
4. Accurate and easily-understood information about your diagnosis, health plan, health care professionals, and health care facilities.
5. To choose health care providers who can give you high-quality health care as needed.
6. To know the name of every person on your care team from the front office to the physician and the functions they will perform.
7. Receive complete and current information concerning your diagnosis, treatment, and prognosis in terms you can be reasonably expected to understand.
8. Help with comprehension in the event you have a physical or mental disability, or do not understand something so you can make informed decisions about your health plan.
9. Request a second opinion from another physician.
10. Participate actively in determining a course of treatment for yourself. Your Responsibilities
11. Refuse treatment and be told what effect this may have on your health, and to be informed of the other potential consequences of refusal.
12. Have privacy while in our care and confidentiality of all information and records regarding your care.
13. Refuse to participate in research or discontinue participation in research at any time.
14. Examine and receive an explanation of your bill.
15. Designate an individual to represent you in making decisions regarding your treatment or care.
16. to receive information regarding rules, policies, and responsibilities that apply to their conduct.

Your Responsibilities as a Patient

As a patient, you have the responsibility to:

1. Cooperate with your caregivers and follow the plan of care agreed upon by you and your care team.
2. Provide accurate and complete information regarding your care and medical history as well as current medications.
3. Respect the privacy and rights of others.
4. Provide proper identification when at the office or when inquiring about your care via telephone.
5. Notify the office in a timely manner when unable to keep an appointment.
6. Inform the care team of any changes in your condition or new symptoms.
7. Follow recommended treatment plans or refusing treatment.
8. Request medical records as needed.
9. Inform the health care team of changes in your decision to participate in research.
10. Meet the financial obligation of their treatment in a timely manner.

Rules and regulations pertaining to patient conduct are necessary to ensure that all patients are treated fairly and feel secure while in our care. Your cooperation in these responsibilities will help us provide quality care and services. We are available to answer questions about your rights as a patient, provide information and referrals, solve problems, investigate complaints and act as your advocate. To reach a patient representative, call 702-877-1887.

KSOSN KIDNEY SPECIALISTS OF SOUTHERN NEVADA

Date:	Personal/ Family History

PATIENT INFORMATION

PATIENT NAME (LAST)	(FIRST)	(M.I)	DOB:

PAST MEDICAL HISTORY (Please mark all conditions that you have ever had)

- ☐ Dialysis
- ☐ Prostrate Trouble
- ☐ Vasculitis
- ☐ Kidney Transplant
- ☐ Blood clots
- ☐ Other Organ Transplant
- ☐ Gout
- ☐ Kidney Disease or Nephritis
- ☐ Asthma
- ☐ Liver Trouble or Hepatitis
- ☐ Blood in Urine
- ☐ Kidney Stones
- ☐ Urinary Obstruction
- ☐ Protein in Urine
- ☐ Emphysema
- ☐ Bronchitis
- ☐ Heart Disease
- ☐ Anemia
- ☐ Kidney Cysts
- ☐ Heart Failure
- ☐ Kidney Cancer
- ☐ Stroke
- ☐ Other Cancer
- ☐ High Blood Pressure
- ☐ Diabetes
- ☐ Thyroid Disease
- ☐ Arthritis
- ☐ Lupus
- ☐ Osteoporosis
- ☐ Other Autoimmune Disease
- ☐ Deafness
- ☐ High Cholesterol

SOCIAL HISTORY (Please mark all that apply to you)

Tobacco Use (Any form) ☐ Current- every day ☐ Current- some days ☐ Previous ☐ Never

Alcohol Use ☐ Yes ☐ No

If yes, Number of times per day: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7+

Number of times per week: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7+

Do you use recreational drugs? ☐ Yes ☐ No

When was your last flu vaccine? ________________

Who do you live with? ☐ Spouse ☐ Spouse and/ or children ☐ Alone ☐ Other: ________________

Highest level of education: ☐ High School ☐ Technical School ☐ College ☐ Post Graduate

PROCEDURES (Please mark all that apply to you)

Have you ever had an ultrasound of the Kidney? ☐ Yes ☐ No

If yes, when and where?_____________________________________

Have you ever had a Kidney Biopsy? ☐ Yes ☐ No

If yes, when and where? _____________________________________

Have you ever had a Kidney Transplant? ☐ Yes ☐ No

If yes, when and where? _____________________________________

Have you ever had a Chest X-Ray? ☐ Yes ☐ No

If yes, when and where? _____________________________________

SURGICAL HISTORY (Please mark all that apply to you)

General Surgery
- ☐ Appendectomy
- ☐ Cholecystectomy
- ☐ Colectomy
- ☐ Gastric Bypass
- ☐ Hernia Surgery
- ☐ Mastectomy
- ☐ Thyroidectomy

Gynecology
- ☐ C-Section
- ☐ Hysterectomy

If yes, was it due to cancer?

☐ Yes ☐ No

Urology
- ☐ Kidney Stone Removal

Heart Procedure
- ☐ Pacemaker
- ☐ Heart Valve replacement
- ☐ Coronary Stents
- ☐ Cardiac Catheterization
- ☐ Heart Bypass Surgery

If yes, was it single, double, triple, quadruple?

☐ Single ☐ Double

☐ Triple ☐ Quadruple

Nephrology
- ☐ Dialysis Fistula
- ☐ Dialysis Graft
- ☐ Nephrectomy
- ☐ Kidney Transplant

Vascular Surgery
- ☐ Leg artery bypass
- ☐ Carotid endarterectomy
- ☐ Amputation
- ☐ Amputation 2nd
- ☐ Vein Mapping
- ☐ Fistulogram

Nephrology
- ☐ Joint Replacement
- ☐ Prostatectomy
- ☐ Spinal fusion

FAMILY HISTORY (Does anyone in your family currently have or have a history of?)

- ☐ Abnormal bleeding or clotting
- ☐ Alcoholism
- ☐ Allergies
- ☐ Blood Disease
- ☐ Deafness
- ☐ Diabetes
- ☐ Dialysis
- ☐ Heart Attack
- ☐ High blood pressure
- ☐ Kidney Disease
- ☐ Lupus
- ☐ Migraine
- ☐ Polycystic Kidney Disease
- ☐ Psychiatric disease or suicide
- ☐ Seizures or epilepsy
- ☐ Transplant
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ Kidney Cancer
- ☐ Liver Cancer
- ☐ Lung Cancer
- ☐ Prostate Cancer
- ☐ Skin Cancer
- ☐ Thyroid Cancer
- ☐ Other Cancer

REVIEW OF SYMPTOMS (Please mark all that apply)

Constitutional
- ☐ Fatigue
- ☐ Weight Loss
- ☐ Weight Gain
- ☐ Poor Sleep
- ☐ Loss of Appetite
- ☐ Fever

Eyes
- ☐ Problems
- ☐ Pain/ Discharge

ENT
- ☐ Hearing Loss

Cardiovascular
- ☐ Chest Pain
- ☐ Palpitations
- ☐ Ankle Swelling

Musculoskeletal
- ☐ Foot or Joint Pain
- ☐ Backache

Respiratory
- ☐ Shortness of Breath
- ☐ Cough
- ☐ Wheezing

Gastrointestinal
- ☐ Abdominal Pain
- ☐ Nausea & Vomiting
- ☐ Constipation
- ☐ Diarrhea

REVIEW OF SYMPTOMS CONT. (Please mark all that apply)

Genitourinary

☐ Difficulty in Urinating
☐ Painful Urination
☐ Blood in Urine
☐ Blood in Stool

Skin

☐ Rash
☐ Ulcers

Nervous

☐ Headaches
☐ Dizziness
☐ Fainting

Psychiatric

☐ Anxiety
☐ Depression

Additional Comments: