



Welcome to Branson Nephrology and Dialysis, LLC.

As your new health care providers, we look forward to serving you and hope that together we can build a relationship that will ensure you receive the highest quality care and service.

Following your will find some information that may be helpful to you as you become part of our practice. If you should have any further questions please feel free to contact us. Our office number is 417-334-8288 and our fax number 417-334-6966.

#### **HOURS OF OPERATION**

- Office hours: Monday through Thursday, 8:00 AM to 5:00 PM. Fridays from 8:00 AM to 2:00 PM
- Please call as soon as possible to cancel if you are unable to make an appointment so that the appointment time can be offered to other patients.

#### **PAYMENTS AND INSURANCE**

We will submit the charges for our services to your insurance for you. If you have no insurance, payment is required at the time of service. Payment is always expected at the time of service unless you have made prior arrangements with our Billing Department. Co-payments are to be paid on the day of service.

#### **INVOLVEMENT IN YOUR HEALTHCARE**

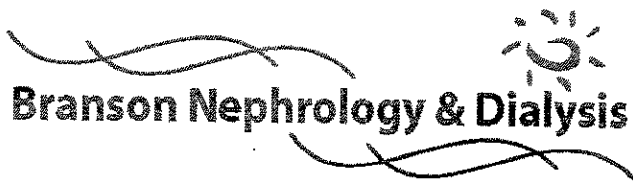
Everyone has a role in making healthcare safe. Our staff is working to make your health care safety a priority. You, as a patient, can play a vital role in making your care safe by becoming an active, involved and informed member of your healthcare team. So **SPEAK UP:**

- S** – Speak up if you have any questions or concerns and if you don't understand, ask again
- P** – Pay attention to the care you are receiving and make sure you are getting the right treatment and medication
- E** – Educate yourself about your diagnosis and your treatment plan
- A** – Ask a trusted family member or companion to be your advocate
- K** – Know what medications you take and why you take them
- U** – Use a healthcare facility that provides quality care
- P** – Participate in all decisions about your treatment

#### **HELP US TO HELP YOU MORE EFFICIENTLY:**

- Let us know if you move, change your insurance, job, or telephone number.
- We have a \$25.00 no-show fee and a \$15.00 less than 24 hr notice cancellation/reschedule fee.
- If a problem arises, tell us. We will do the best we can to help you with it.
- Have your pharmacy fax us your medication refill request.
- Labs are needed for each office appointment and need to be done at least 1 week prior to the appointment.
- The nurse will ask for a urine sample and will have you fill out a review of systems form at each visit.
- Please remember to bring your insurance cards and all medications, even over the counter, to your visit.

**LET'S WORK TOGETHER TO MAINTAIN GOOD HEALTH!**



**Patient Demographic**

**PERSONAL DATA (please print):**

Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Sex (**circle one**): M F Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Marital Status (**please check one**): \_\_\_\_\_ Married \_\_\_\_\_ Widowed \_\_\_\_\_ Single \_\_\_\_\_ Divorced  
Race/Ethnicity: \_\_\_\_\_ Language: \_\_\_\_\_ E-mail address: \_\_\_\_\_  
First Name: \_\_\_\_\_ Middle Name: \_\_\_\_\_ Last Name: \_\_\_\_\_  
Street Address: \_\_\_\_\_ City/ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone#: \_\_\_\_\_ Mobile Phone#: \_\_\_\_\_ Alt Phone#: \_\_\_\_\_  
Employment Status (**please check one**): \_\_\_\_\_ Employed \_\_\_\_\_ Retired \_\_\_\_\_ Disabled \_\_\_\_\_ Unemployed  
Employed by: \_\_\_\_\_ Address: \_\_\_\_\_  
City/State: \_\_\_\_\_ Zip: \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ EXT \_\_\_\_\_  
Referring Physician: \_\_\_\_\_ Referring MD Phone#: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**EMERGENCY CONTACT INFORMATION:**

In the event of an emergency, please contact:

Full Name: \_\_\_\_\_ Daytime Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
Relationship to Patient \_\_\_\_\_ Other Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**INSURANCE INFORMATION (please bring cards for us to copy):**

|   |   |
|---|---|
| Primary Insurance: _____                    | Primary Insurance: _____                    |
| ID#: _____                                  | ID#: _____                                  |
| Group#: _____                               | Group#: _____                               |
| Group Name: _____                           | Group Name: _____                           |
| Effective Date ____/____/____               | Effective Date ____/____/____               |
| Primary Cardholder: _____                   | Primary Cardholder: _____                   |
| Patient's relationship to cardholder: _____ | Patient's relationship to cardholder: _____ |
| Social Security # _____ - _____ - _____     | Social Security # _____ - _____ - _____     |
| Sex ( <b>please circle one</b> ): M F       | Sex ( <b>please circle one</b> ): M F       |
| Date of Birth ____/____/____                | Date of Birth ____/____/____                |

## HEALTH QUESTIONNAIRE

PATIENT NAME: \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Why were you referred here by your primary care physician? What symptoms are you having?

\_\_\_\_\_

\_\_\_\_\_

DRUG ALLERGIES/REACTIONS:

\_\_\_\_\_

**Patient Medical History**

SURGERIES: DATE/OPERATION

VACCINATIONS: (YEAR LAST VACCINATED)

INFLUENZA \_\_\_\_\_ HEPATITIS B \_\_\_\_\_

PNEUMONIA \_\_\_\_\_

OTHER HOSPITAL STAYS, INJURIES, ILLNESSES AND DATES

\_\_\_\_\_

\_\_\_\_\_

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> CANCER                                 | <input type="checkbox"/> KIDNEY DISEASE   | <input type="checkbox"/> RENAL TRANSPLANT         |
| <input type="checkbox"/> DIABETES                               | <input type="checkbox"/> LUNG DISEASE     | <input type="checkbox"/> HIGH BLOOD PRESSURE      |
| <input type="checkbox"/> DIALYSIS                               | <input type="checkbox"/> HEART DISEASE    | <input type="checkbox"/> ABNORMAL BLEEDING        |
| <input type="checkbox"/> URINARY INFECTIONS                     | <input type="checkbox"/> HEAD INJURY      | <input type="checkbox"/> PACEMAKER                |
| <input type="checkbox"/> STROKE                                 | <input type="checkbox"/> HIGH CHOLESTEROL | <input type="checkbox"/> CONGESTIVE HEART FAILURE |
| <input type="checkbox"/> TAKING NSAID's FOR LONG PERIOD OF TIME | <input type="checkbox"/> THYROID DISEASE  |   |

**FAMILY HISTORY**

CHECK ILLNESSES OF BLOOD RELATIVES AND SPECIFY WHO:

- |   |  |
|---|--|
| <input type="checkbox"/> CANCER _____           | <input type="checkbox"/> KIDNEY DISEASE _____      |
| <input type="checkbox"/> RENAL TRANSPLANT _____ | <input type="checkbox"/> DIABETES _____            |
| <input type="checkbox"/> ARTHRITIS _____        | <input type="checkbox"/> HIGH BLOOD PRESSURE _____ |
| <input type="checkbox"/> DIALYSIS _____         | <input type="checkbox"/> HEART DISEASE _____       |
| <input type="checkbox"/> LUNG DISEASE _____     |  |

**SOCIAL HISTORY**

- |                                       |  |  |                                      |
|---------------------------------------|--|--|--------------------------------------|
| <input type="checkbox"/> LIVING ALONE | <input type="checkbox"/> MARRIED             | <input type="checkbox"/> CAFFEINE                    | <input type="checkbox"/> ALCOHOL USE |
| <input type="checkbox"/> WITH SPOUSE  | <input type="checkbox"/> SINGLE              | <input type="checkbox"/> TOBACCO PKS ____ YEARS ____ |                                      |
| <input type="checkbox"/> WITH PARENTS | <input type="checkbox"/> WIDOWED (YEAR ____) | <input type="checkbox"/> ILLICIT DRUG USE            |                                      |
| <input type="checkbox"/> NURSING HOME | <input type="checkbox"/> CHILDREN # _____    | <input type="checkbox"/> EXERCISE REGULARLY          |                                      |
| <input type="checkbox"/> OTHER (____) |  | <input type="checkbox"/> EMPLOYED                    | <input type="checkbox"/> RETIRED     |
|                                       |  | <input type="checkbox"/> ON DISABILITY               |                                      |

# REVIEW OF SYSTEMS

PLEASE CHECK ANY CURRENT PROBLEMS.

| YES                      | BODY                                     | YES  | GENITOURINARY                      |
|--------------------------|--|--|------------------------------------|
| <input type="checkbox"/> | Fever                                    | <input type="checkbox"/>   | Pain during urination              |
| <input type="checkbox"/> | Chills                                   | <input type="checkbox"/>   | Increased urinary frequency        |
| <input type="checkbox"/> | Night Sweats                             | <input type="checkbox"/>   | Blood in urine                     |
| <input type="checkbox"/> | Decrease in Appetite                     | <input type="checkbox"/>   | Change in urine appearance         |
| <input type="checkbox"/> | Feeling tired or poorly                  | <input type="checkbox"/>   | Feeling of urinary urgency         |
| <b>HEAD</b>              |  | <input type="checkbox"/>   | Frequent Daytime urination         |
| <input type="checkbox"/> | Headache                                 | <input type="checkbox"/>   | Frequent Nighttime urination       |
| <input type="checkbox"/> | Facial pain                              | <input type="checkbox"/>   | Unable to restrain urination       |
| <input type="checkbox"/> | Sinus pain                               | <input type="checkbox"/>   | Kidney Stones                      |
| <input type="checkbox"/> | Change in Vision                         | <input type="checkbox"/>   | <b>MUSCULOSKELETAL</b>             |
| <input type="checkbox"/> | Frequent Nosebleeds                      | <input type="checkbox"/>   | Joint pain, or stiffness localized |
| <input type="checkbox"/> | Nasal/Sinus Congestion                   | <input type="checkbox"/>   | Muscle aches                       |
| <input type="checkbox"/> | Tremors/Shakes                           | <input type="checkbox"/>   | Gout                               |
| <input type="checkbox"/> | Loss of Consciousness                    | <input type="checkbox"/>   | Joint swelling, localized          |
| <input type="checkbox"/> | Seizures/Convulsions                     | <b>NEUROLOGICAL</b>  |                                    |
| <input type="checkbox"/> | Difficulty Walking                       | <input type="checkbox"/>   | Dizziness                          |
| <b>EYE</b>               |  | <input type="checkbox"/>   | Vertigo                            |
| <input type="checkbox"/> | Eyesight problems                        | <input type="checkbox"/>   | Fainting                           |
| <input type="checkbox"/> | Eye's light sensitive                    | <input type="checkbox"/>   | Motor disturbances                 |
| <input type="checkbox"/> | Itching of the eyes                      | <input type="checkbox"/>   | Sensory disturbances               |
| <input type="checkbox"/> | Eye Pain                                 | <b>PSYCHOLOGICAL</b>   |                                    |
| <b>EAR/NOSE/THROAT</b>   |  | <input type="checkbox"/>   | Sleep disturbances                 |
| <input type="checkbox"/> | Earache/Ringing in the ears              | <input type="checkbox"/>   | Anxiety                            |
| <input type="checkbox"/> | Hearing loss                             | <input type="checkbox"/>   | Depression                         |
| <input type="checkbox"/> | Nasal discharge                          | <b>SKIN</b>  |                                    |
| <input type="checkbox"/> | Mouth sores                              | <input type="checkbox"/>   | Pruritus                           |
| <input type="checkbox"/> | Bleeding gums                            | <input type="checkbox"/>   | Skin lesions                       |
| <input type="checkbox"/> | Hoarseness                               | <input type="checkbox"/>   | Rashes                             |
| <input type="checkbox"/> | Throat pain                              | <b>ENDOCRINE</b>   |                                    |
| <b>NECK</b>              |  | <input type="checkbox"/>   | Excessive sweating                 |
| <input type="checkbox"/> | Neck pain                                | <input type="checkbox"/>   | Excessive thirst                   |
| <input type="checkbox"/> | Neck stiffness                           | <b>GASTROINTESTINAL</b>  |                                    |
| <input type="checkbox"/> | Lump or swelling in neck                 | <input type="checkbox"/>   | Difficulty swallowing              |
| <b>CARDIOVASCULAR</b>    |  | <input type="checkbox"/>   | Heartburn                          |
| <input type="checkbox"/> | Chest pain or discomfort                 | <input type="checkbox"/>   | Nausea                             |
| <input type="checkbox"/> | Fast heart rate                          | <input type="checkbox"/>   | Vomiting                           |
| <input type="checkbox"/> | Palpitations                             | <input type="checkbox"/>   | Stomach pain                       |
| <input type="checkbox"/> | Swelling – Both legs and feet            | <input type="checkbox"/>   | Diarrhea                           |
| <input type="checkbox"/> | Swelling - One leg or foot               | <input type="checkbox"/>   | Black or bloody stools             |
| <b>PULMONARY</b>         |  | <input type="checkbox"/>   | Constipation                       |
| <input type="checkbox"/> | Difficulty breathing during exertion     | <b>BLOOD</b>   |                                    |
| <input type="checkbox"/> | Cough                                    | <input type="checkbox"/>   | Easy Bruising                      |
| <input type="checkbox"/> | Wheezing                                 | <input type="checkbox"/>   | Bleed easily                       |
| <input type="checkbox"/> | Chest congestion                         | <b>Have you been in the hospital since your last visit here?</b> |                                    |
| <input type="checkbox"/> | Snoring loudly                           | <input type="checkbox"/>   |                                    |
| <input type="checkbox"/> | Currently Smoking, if yes how much _____ | <b>TODAY'S DATE:</b> _____                                       |                                    |
| <b>YOUR NAME:</b> _____  |  |  |                                    |



**AUTHORIZATION FOR RELEASE OF INFORMATION**  
**AND**  
**ASSIGNMENT OF BENEFITS**

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

1. I hereby authorize you to release any information acquired in my examination and treatment to the appropriate insurance company for any associated charges.
2. I request that Payment be made directly to Branson Nephrology, L.L.C. on any bills for services furnished by providers or licensed personnel employed by them.
3. In cases where Medicare is the primary insurance, I understand that I am only responsible for the deductible and coinsurance at the Medicare allowable charge amount. For any services that are non-covered under the Medicare program, I agree to pay the usual and customary charge for that procedure.

\_\_\_\_\_  
**Patient Signature**

\_\_\_\_\_  
**Date**

By: \_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Relationship to Patient**



### Authorization to Release Medical Information

I, \_\_\_\_\_, hereby authorize John R. Martinez, MD or any associate of Branson Nephrology, L.L.C. who is licensed by the state of Missouri as an MD, PA-C, RN or LPN to release all medical information relating to my medical condition, plan of treatment, medications or other pertinent medical information to the following individuals or Physicians:

Primary Physician(s) *(list all physicians you are currently seeing)*

Primary Care / Family Practice \_\_\_\_\_

Other : \_\_\_\_\_

Other : \_\_\_\_\_

Family members or guardians:

\_\_\_\_\_ Relationship to Patient \_\_\_\_\_

\_\_\_\_\_ Relationship to Patient \_\_\_\_\_

\_\_\_\_\_ Relationship to Patient \_\_\_\_\_

I understand that by signing this authorization, the above named individuals may discuss my medical history and any current medical conditions, plan of treatment, medications or other pertinent medical information with any licensed member of Branson Nephrology, L.L.C.

### Medical Records Policy

It is the standard operating procedure of Branson Nephrology to release a copy of my medical record to any physician who is known to be involved in my medical treatment. A signed medical records release form will be obtained prior to the records being released.

As a patient of Branson Nephrology, it is my right to obtain a copy of my medical chart after submitting a written request and allowing a one week period for the records to be processed. I understand that my medical record will only be released to me and only to other members of my family or authorized agent, including those authorized above.

Patient Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Witness \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

**Branson Nephrology / Branson Dialysis**  
**101 Skaggs Road, Ste 301**  
**Branson MO 65616**  
**417-334-8288**

**ACKNOWLEDGEMENT OF RECEIPT OF  
NOTICE OF PRIVACY PRACTICES**

*I may refuse to sign this acknowledgement.*

I have received a copy of Branson Nephrology, LLC and Branson Dialysis, LLC,  
Notice of Privacy Practices.

\_\_\_\_\_  
Print Name of Patient

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

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**OFFICE USE ONLY**

We attempted to obtain written acknowledgement of receipt of our Notice  
of Privacy Practices, but it could not be obtained because of the following:

Patient Refused to Sign  
Communication barriers prohibited obtaining acknowledgement  
Emergency situation prevented us from obtaining  
acknowledgement  
Other: \_\_\_\_\_  
\_\_\_\_\_

**Staff Instructions:**

1. All new patients receive the Notice of Privacy Practices on their first visit.
2. Verify the presence of the Acknowledgement Statement in all office patient charts and if not present, reissue the Notice of Privacy Practices at the first available opportunity.
3. File the Acknowledgment Statement in the medical record with the patient demographic paperwork.