Doreen Bett, D.O.
Susan K. Ciampaglia, D.O., FACOI
James A. Groff, D.O., FACOI
Navdeep Kaur, M.D.
Jeffrey N. Levine, D.O., FACOI
Jeffrey L. Martin, M.D., FASN
Charles H. Rodenberger, M.D.
David I. Somerman, D.O.
Rajiv Sharma, M.D.
Marc H. Weiner, M.D.

Hypertension and Kidney Specialists

Kathryn E. Couch, CRNP
Cheryl L. Good, CRNP
Jennifer L. Groff CRNP
Dana R. Nikles, CRNP
Anne M. Pryzbylkowski, CRNP
Allison M. Sileo, CRNP

Dear Patient:

Welcome to Hypertension and Kidney Specialists. The physicians and staff of our medical practice are dedicated to providing you with the highest standard of medical care.

Enclosed you will find two forms: Patient History Form & Patient Information Form. Please fill out these forms, and present them to the receptionist, along with your insurance card, prescription card and list of medications, when you arrive for your appointment. If you filled out the forms online through mylghealth, please print them and bring them with you to your appointment.

We encourage you to bring all your medications with you or bring a detailed medication list. This review of medications should include any over the counter drugs you may be taking.

Please note that if your insurance requires a referral it is your responsibility to have this at the time of service. Unfortunately your appointment will have to be postponed until you obtain a referral. Insurance co-pays are due at the time of service. Failure to provide your co-pay will result in the cancellation of your appointment.

Please arrive fifteen (15) minutes prior to your appointment, to ensure that all of the necessary paperwork has been completed. Please be prepared to provide a urine sample, in the office, at this time.

If you have any questions or concerns prior to your appointment, please feel free to call our office and our staff will be happy to assist you.

Thank you,
HKS Physicians

Appointment Location

___ Lancaster General Health Campus
Bldg. 2110 Harrisburg Pike
Suite 310
Lancaster, PA 17604

____ Cocalico Center for Health
73 West Church Street
Stevens, PA 17578

Hypertension and Kidney Specialists

Patient History Form

The following information is very important to your health. Please take the time to fully and accurately fill out this form.

Name: _____ **Date of Birth**: _____

Which physician or practice referred you to Hypertension and Kidney Specialists

_____

What is your understanding of why you are being seen? _____

Current Medical Problems (examples: diabetes, high blood pressure, high cholesterol, other medical problems for which you take medications, etc)

1)_____ 2)_____ 3)_____

4)_____ 5)_____ 6)_____

Others_____

Past Medical Problems that are no longer active (example heart attack, stroke, cancer that is in remission)

1)_____ 2)_____ 3)_____

4)_____ 5)_____ 6)_____

Others_____

Past Surgeries you have had (example appendix removed, gallbladder removed, etc)

1)_____ 2)_____ 3)_____

Others_____

Do you have a History in Your Family of:

Kidney Disease including anyone
on dialysis or needed kidney transplant No Yes
Hypertension "high blood pressure" No Yes
Blood or protein in the urine No Yes
Rheumatologic condition such as No Yes
Lupus, Rheumatoid Arthritis No Yes
If yes to the above, please explain who
_____

Have you or do you:

Smoke No Yes Quit? _____
Drink Alcohol No Yes
if yes how much_____
Ever used illicit or
recreational drugs No Yes
if yes which ones_____
Drink caffeine No Yes
if yes how much_____

Are you allergic to any medications or environmental allergens (food, bees, etc):

_____

Have you ever received a Pneumonax (pneumonia vaccine)? No Yes (if yes when)_____
Did you receive influenza vaccine this year? No Yes
List All Medications (including Over the Counter and herbal medications) currently being taken or stopped in last month. **Please bring all your medication bottles with you to your appointment.**

_____

_____

_____

_____

Do you follow special diet (low salt, diabetic, etc) _____

Do You Have or Have History of

Weight Loss or Weight Gain	No	Yes	**Pain with urination**	No	Yes
If Yes how many pounds_____			**Blood in urine**	No	Yes
Fevers or Night Sweats	No	Yes	**Kidney stones**	No	Yes
Vision Problems	No	Yes	**Frequent Bladder Infection**	No	Yes
Bleeding in eye from high blood			**Are you up at night to urinate**	No	Yes
pressure or diabetes	No	Yes	**Painful Joints**	No	Yes
Diabetes in your eye(s)	No	Yes	**Numbness in hands or feet**	No	Yes
Problems with Sinuses	No	Yes	**Weakness in arms or legs**	No	Yes
Persistent Cough	No	Yes	**Bruise or bleed easily**	No	Yes
Coughing up blood	No	Yes	**Skin Rash**	No	Yes
Tuberculosis or exposure to Tb	No	Yes	**Depressed Mood**	No	Yes
Chest pain or tightness	No	Yes	**Confusion**	No	Yes
Swollen legs, feet, around eyes	No	Yes	**Excessive Thirst**	No	Yes
Irregular or rapid heart beat	No	Yes	**Loss of appetite**	No	Yes
Do you take medications for upset			**Bad taste in your mouth**	No	Yes
stomach/heartburn	No	Yes	**Have you ever been denied**		
Nausea/vomiting	No	Yes	**ability to donate blood**	No	Yes
Jaundice or Hepatitis	No	Yes			

I attest that the above information is true and correct to the best of my knowledge.

Name: _____ Date: _____

Office use only:

Reviewed by _____ Date:_____

Hypertension and Kidney Specialists

Name: _____
(First) (M.I) (Last)

Address: _____

City: _____ **State:** _____ **Zip:** _____

Date of Birth: _____/_____/_____ **Sex: ( )** Male **( )** Female

SSN#: _____-_____-_____ **Marital Status: ( )** S **( )** M **( )** D **( )** W

Language Preference if not English: _____

Race: _____ (Black/African American, White, Asian, Pacific Islander, Declined)

Ethnicity: Do you consider yourself Hispanic or Latino: **( )** Yes **( )** No **( )** Declined

Emergency Contact:

Spouse: _____ Phone #: _____
(or someone who lives in your home)

Other(s):_____ Phone #: _____
(children/siblings *someone who does not live in your home)

May we discuss your medical condition with your emergency contact(s)? **( )** Yes **( )** No

<u>Communication Methods</u>: * check all that apply

( ) Preferred Daytime Phone **#:** _____
( ) Evening Phone **#:** _____
( ) Cell Phone **#:** _____
( ) Other**:** _____

( ) May leave message to return call
( ) Ok to leave detailed message
( ) Not ok to leave message
( ) Patient Portal **coming soon
( ) E-mail **coming soon

Cont'd on page 2 ⇨

Release of Information:

( ) I authorize the staff of HKS to release information and/or discuss my care with the following person(s).

( ) Spouse/Significant other: _____

( ) Child(ren): _____

_____

( ) Sibling(s): _____

( ) Other: _____

This **Release of Information** will remain in effect until terminated by me in writing.

**By signing this I understand that only the persons listed above are authorized to discuss my medical care.

Anyone requesting to discuss my medical care that is NOT listed above will be refused.

** If you have a designated **POA** (Power of Attorney), please provide documentation.

Who is your Family Doctor: _____

Please list any other Specialists that you see:

1. (name)_____ (group)_____

2. (name)_____ (group)_____

3. (name)_____ (group)_____

4. (name)_____ (group)_____

Signature: _____ **Date:** _____