PATIENT INFORMATION FORM

Dear Sir/Madam,

Welcome to Diablo Nephrology. Our physicians, nurse practitioners, and staff look forward to caring and providing paramount care to your kidney-related needs.

Please be sure to contact your provider and ask them to complete the **Referral Form** found on our website (www.diablonephrology.com). They can contact our office and we can fax them the form, as well.

Once your provider has sent us your information, we will contact you to schedule an appointment with one of our physicians. Please take time to complete this information form and bring it to your scheduled appointment.

Please arrive 20 minutes before your scheduled appointment time and bring the following:

- Health Insurance Card (Primary and Secondary insurances, if applicable).
- Co-pay, if applicable.
- Completed patient information form.
- Please be prepared to give a urine sample at the time of the appointment.

Thank you. We appreciate your trust in us to care for your health.

Sincerely,
Diablo Nephrology Medical Group

Walnut Creek Office
110 Tampico, Ste 200
Walnut Creek, CA 94598
Fax: 925-944-1957
Main: 925-944-0351

Concord Office
2222 East St, Ste 305
Concord, CA 94520
Fax: 925-686-8443
Main: 925-686-1230

Antioch Office
2370 Country Hills Dr, Ste 101
Antioch, CA 94509
Fax: 925-779-9672
Main: 925-779-9635

PATIENT INFORMATION FORM

Date: ____________________

Patient Name: ___________________________________ **Birth Date:** ___________

Gender: Male / Female **Social Security Number:** ________________________

Home Address: ____

City: ______________________ **Zip Code:** _______________

Phone Number: ___________________ **Alternative Number:** __________________

Occupation: ______________________ **Work Phone Number:** ________________

Employer: ____

Work Address: ____

Marital Status *(circle)*: Single / Married / Widowed / Divorced / Separated

Spouse: ______________________ **Spouse Phone Number:** __________________

Emergency Contact: _________________________ **Phone Number:** ___________

Relationship: ___________________

Do you have a power of attorney or living will? Y / N

If yes, please provide a copy for our offices.

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If someone other than the patient is responsible for payment, complete below:

Name: ____ Phone: _____________

Home Address: __________________________________ SSN: ______________

Employer: ______________________________ Work Number: _______________

INSURANCE INFORMATION

Primary Carrier: ___________________________________ ID#: _____________

Secondary Carrier: _________________________________ ID#: _____________

Other Carrier: _____________________________________ ID#: _____________

As patient or as legal guardian of a minor patient, I agree to pay for all services rendered. This office may bill my insurance carrier as needed. ASSIGNMENT & RELEASE: I hereby assign my insurance benefits to be paid directly to DIABLO NEPHROLOGY MEDICAL GROUP, INC. I am financially responsible for non-covered services. I authorize the physician to release any information necessary to process this request.

Date: ________________ Signed: ______________________________________

All Medicare patients must sign lifetime beneficiary claim authorization: I request that payment of authorized Medicare benefits be made either to me, or on my behalf to DIABLO NEPHROLOGY MEDICAL GROUP, INC. for any services furnished by that physician.

Date: ________________ Signed: ______________________________________

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PATIENT INFORMATION FORM

Pharmacy: ___________________________ **Pharmacy Phone #:** _________________

City: ____________________ **Major Street/Cross Street:** _______________________

Drug Name (include OTC medicines)	**Dose** (mg)	**Directions** (ie, # of tablets & frequency)	**Prescribing MD**

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Medical Problems: Please include year of diagnosis, if possible.

1.	11.
2.	12.
3.	13.
4.	14.
5.	15.
6.	16.
7.	17.
8.	18.
9.	19.
10.	20.

Surgeries: Please include year of procedure, if possible.

1.	7.
2.	8.
3.	9.
4.	10.
5.	11.
6.	12.

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Dear Patients,
In compliance with the nationally-mandated “meaningful use” for electronic health records (EHR), we need the information below in your medical chart. Please check one in each category. Thank you.

Ethnicity: ☐ Hispanic/Latino. ☐ Not Hispanic/Latino.

Primary Race: ☐ White ☐ African-American/Black ☐ American Indian/Alaska Native
☐ Asian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Vietnamese
☐ Native Hawaiian/Pacific Islander ☐ Samoan ☐ Guamanian/Chamorro
☐ Other ______________________

Language: ☐ English ☐ Spanish ☐ Mandarin ☐ Cantonese ☐ Korean ☐ Japanese
☐ Tagalog ☐ Thai ☐ Vietnamese ☐ Hindi ☐ German ☐ French ☐ Greek ☐ Italian
☐ Portuguese ☐ Polish ☐ Russian ☐ Yiddish ☐ Arabic ☐ Persian ☐ French Creole
☐ Other __________________

Smoking Status:
☐ Current, everyday smoker. Year started: ___________. Packs-per-day: ________.
☐ Current, someday smoker. Year started: ___________. Packs-per-day: ________.
☐ Former smoker. Year started: __________. Year quit: _________. Packs-per-day: ________.
☐ Never smoked.

Allergies: Please list name of medication and reaction:

____

____

____

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