Dear Patient,

Thank you for choosing Dallas Renal Group! We have attached your new patient paperwork that needs to be filled out prior to your appointment.

**Please bring the following to your appointment:**

- New Patient Paperwork
- Picture ID
- Insurance card
- All your medications, including any over the counter medications.

If you forget the paperwork packet, please arrive 15 minutes prior to your appointment time, so that you may fill it out.

Thank you in advance for your assistance

Dallas Renal Group
Phone: (972)274-5555
Fax: (972)274-5663
PATIENT INFORMATION: (Please use full legal name, no nickname)

*Last Name: ____________________________  *First Name: ____________________________  Middle Initial: _____

*Address: ________________________________________________________________

City: ____________________________  State: _____  Zip code: __________  Home Phone: (___)______________

Cell Phone: (___) - __________  *Social Security #: ____________________________________________

*Date of Birth: _______  Age: ___  *Sex: ___  Marital Status: _______  Drivers Lic. #: ___________

*Employer Name and Address: _______________________________________________________________

__________________________________________________________  Work Phone #: (___) - _____

Emergency Contact Name: _______________________________________  Emergency phone #: (___) - _____

Primary Care Physician Name: ____________________________  PCP office telephone #: (___) - _____

Please tell us how you heard about us: ____________________________  Referred by: __________________________

GUARANTOR INFORMATION: (If different from patient)

*Last Name: ____________________________  *First Name: ____________________________  Middle Initial: _____

*Date of Birth: ___________  *Social Security #: __________________  Relationship: ________________

*Employer Name: ______________________________________  Phone #: _______________________

INSURANCE INFORMATION: (OR COPY OF INSURANCE CARD)

Primary: ____________________________  Address: ________________________________________

Phone #: ____________________________  ID #: ____________________________  Group #: ____________

Subscriber: ____________________________  Relationship: ____________________________

Secondary: ____________________________  Address: ______________________________________

Phone #: ____________________________  ID #: ____________________________  Group #: ____________

Subscriber: ____________________________  Relationship: ____________________________

COPAY $__________________________  DEDUCTIBLE $__________________________
ASSIGNMENT OF INSURANCE BENEFITS:
I hereby authorize direct payment of my insurance benefits to Dallas Renal Group or the physician individually for services rendered to my dependents or me by the physician or under his/her supervision. I understand that it is my responsibility to know my insurance benefits and whether or not the services I am to receive are covered benefit. I understand and agree that I will be responsible for any co-pay or balance due.

MEDICARE/ MEDICAID/ INSURANCE BENEFITS:
I certify that the information given by me in applying for payment under these programs is correct. I authorize the release of any of my or my dependent’s records that these programs may request. I hereby direct that payment of my or my dependent’s authorized benefits be made directly to the Dallas Renal Group or the physician on my behalf.

AUTHORIZATION TO RELEASE NON-PUBLIC PERSONAL INFORMATION:
I certify that I have received and read a copy of the Dallas Renal Group Patient Information Privacy Policy. I hereby authorize Dallas Renal Group or the physician individually to release any of my or my dependent’s medical or incidental non-public personal information that may be necessary for medical evaluation, treatment, consultation, or the processing of insurance benefits.

AUTHORIZATION TO MAIL, CALL, OR E-MAIL:
I certify that I understand the privacy risks of the mail, phone calls, and e-mail. I hereby authorize the Dallas Renal Group staff or my physician to mail, call, or e-mail me with communications regarding my healthcare, including but not limited to such things as appointment reminders, referral arrangements, and laboratory results. I understand that I have the right to rescind this authorization at any time by notifying Dallas Renal Group to that effect in writing.

LAB/ X-RAY/ DIAGNOSTIC SERVICES:
I understand that I may receive a separate bill if my medical care includes lab, x-ray, or other diagnostic services. I further understand that I am financially responsible for any co-pay or balance due for these services if they are not reimbursed by my insurance for whatever reason.

FINANCIAL RESPONSIBILITY AGREEMENT
I understand and agree that I will be financially responsible for any and all charges not paid by my insurance for my visits. This includes medical service or visit, lab testing, and any other screening service or diagnostic ordered by the physician or staff. I understand and agree it is my responsibility and the responsibility of the physician or clinic to know if my insurance will pay for medical service or visit. I understand and agree it is my responsibility to know if my insurance has any deductible, copayment, coinsurance, usual and customary limit, and I agree to make full payment. I understand and agree it is my responsibility to know if the physician or provider I am seeing is contracted in-network with my insurance plan. If the physician I am seeing is not recognized by my insurance company or plan, it may result in claims being denied or higher out of pocket expense to me and I understand this and agree to be financially responsible and make full payment.

Patient signature: ______________________________ Date: ______________________________

Guarantor signature: ______________________________ Date: ______________________________
(If different from patient)

Guarantor name (please print): ______________________________
Individual Patient’s Authorization

**THIS FORM IS TO CONFIRM YOUR AUTHORIZATION TO USE OR DISCLOSE YOUR PROTECTED HEALTH INFORMATION FOR A SPECIAL PURPOSE.**

I ________________ give my authorization to use or disclose my protected (Patient’s Name) health information to the following individual(s) or group(s).

**THIS SHOULD BE NAMES OF RELATIVE OR FRIENDS WE MAY DISCUSS YOUR HEALTH ISSUES WITH. YOU SHOULD LIST AT LEAST ONE PERSON WHO HELPS YOU WHEN YOU ARE ILL.**

________________________________________  __________________________________________

________________________________________  __________________________________________

I authorize Dallas Renal Group or their representative to leave messages via the following: Please number in order of preference. If you don’t want to be contacted by one of the following, do not place a number by it.

_____ Home answering machine

_____ Work voice mail

_____ Cell phone

_____ Text message

_____ EMAIL ________________________________________________________________

I understand that I may revoke this authorization at any time and understand this must be done in writing.

This authorization will end only upon written notice. You must make any additions or deletions from this list in writing.

Name (Print): ________________________________________________________________

Signature: __________________________________________________________________

Date: ___________________________________________________________________

*This must be completed for ANY information to be disclosed to a spouse, family member, organization, or individual that assists you with your medical care, appointments, or insurance.*
PATIENT NAME: ________________________________  DATE: __________________________

ALLERGIES:

________________________________________________________________________________

Review of Systems: Please circle all that apply.

Constitutional:  Fever  Chills  Weight loss/gain  Night sweats  Weakness  Fatigue  Loss of appetite  Nausea

Eyes:  Blurriness  Pain  Discharge  Itchiness

Ears/Nose/Throat:  Hearing loss  Earache  Nasal drainage  Sore throat

Cardio/Peripheral Vascular:  Chest pain  Difficulty breathing  Fatigue  Palpitations  Edema

               Claudication  Numbness

Respiratory:  Shortness of breath  Cough  Wheezing  Asthma

Gastrointestinal:  Abdominal pain  Reflux  Nausea  Vomiting

Genitourinary:  Incontinence  Hematuria/blood in urine  Dysuria  Frequency  Kidney stones

Musculoskeletal:  Joint pain  Back problems  Arthritis  Muscle weakness

Skin:  Skin lesions  Rash  Itching  Hives

Neurologic:  Fainting  Focal Weakness  Numbness  Seizures

Psychiatric:  Psychiatric history  anxiety  depression  memory loss

Endocrine:  Diabetes  Hot and cold intolerance  Thyroid disease

Hematologic:  Anemia  Bleeding  Blood clotting problems  Swollen glands

Sleep:  Snoring  Excessive daytime sleepiness  Witnessed apnea

Others:  Hepatitis type _______  HIV _______  High potassium  Low potassium

Cancer:  ________________________________________________________________

Past Medial History: Please circle any that apply.

High Cholesterol  Gout  Obesity  Hypertension (high blood pressure)

Dementia  Coronary artery disease  Atrial fibrillation

GI Bleeding  Congestive Heart failure  COPD

Osteoarthritis  Stroke  Seizures  Abdominal Aortic Aneurysm

Kidney transplant  Urinary tract infections
Problems not mentioned in 2 sections above: ____________________________________________
____________________________________________________________________________________

Check any surgeries and list year.

__Appendectomy ______  __Kidney biopsy ______  __Tonsillectomy______  __Prostate ______
__Gallbladder ______  __Hysterectomy ______  __Pacemaker________
__Breast biopsy ______  __Mastectomy ______  __Coronary artery bypass________
__Other: _____________________________________________________

Family History: please list family member and disease.

Kidney disease: ____________________________________________
Diabetes: __________________________________________________
Hypertension: ______________________________________________
Heart disease: _______________________________________________
Cancer: _____________________________________________________
Other: ______________________________________________________

Social History: please circle and list explanation.

Marital Status:  Married       Single       Divorced       Separated       Partnered       Spouse deceased
Employed:       Full-time       Part-time       Retired

Current or Previous Occupation: ____________________________

Education:       High school diploma       GED       Some College       College graduate

Tobacco use:       Non-smoker       Previous Smoker       Smoker per day: 1-9  10-19  20-39  40+

Alcohol use:       None       Occasional       Everyday: _____________________________

Drug use:        Never       Previous: ________________________  Current: ________________________

Caffeine consumption: Never       Some       Cups per day: ______

Filled out by: ________________________________  Relationship: ____________________________
Patient Name: ___________________________  Date of Birth: ___________________________

Allergies/ Reactions: ________________________________________________________________

<table>
<thead>
<tr>
<th>Name of Medication</th>
<th>Strength</th>
<th>How Often</th>
<th>What is the medication for?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Date: ___________________________