PERSONAL AND MEDICAL HISTORY FORM

Print this information clearly and update it regularly.

PERSONAL INFORMATION:

Name: ____
Last First MI

Address: ____

City: _________________________ State: ______________________ Zip: ___________

Home Phone ( ) _____________________ Mobile Phone ( ) ____________________

Date of Birth: ____________________ Social Security # _________________________________

Marital Status: Married ( ) Single ( ) Divorced ( )

EMERGENCY CONTACT INFORMATION: ____
Name

Relationship to you: ____

Address: ____

City: ______________________________ State: ______________________ Zip: ____________

Home Phone ( ) ______________________ Mobile Phone ( ) ___________________

POWER OF ATTORNEY: (if applicable) Name: ____

Relationship : ____

Address: ____

Preferred Pharmacy: ____

Preferred Hospital: ____

PRIMARY CARE PHYSICIAN:
Name of Doctor:______________________________ Office Number ( )____________________

Access Surgeon Name: ____

Phone Number: ____

TRANSPORTATION ARRANGEMENT:

How do you get to the Dialysis Center? Drive Self ( ) Relative or friend ( ) check one

Name of Person who transport you: ____

Home Phone: ( ) _____________________ Mobile Phone: ( ) ____________________

INSURANCE INFORMATION:
Medicare Number: ____
(Get information from your red, white and blue Medicare care)

Other Insurance information: ____-

MEDICAL INFORMATION:

List Medical History: ____

List all Medication, dosage and direction:: ____

Allergies or complications: ____

Other (previous surgery)

Your usual dialysis treatment (check one):

_____ Center hemodialysis

_____ Home hemodialysis

_____ Chronic ambulatory peritoneal dialysis (CAPD)

_____ Chronic cycling peritoneal dialysis (CCPD)

_____ Intermittent peritoneal dialysis (IPD)

Protected Health Information Record

You have the right to select how you want confidential medical information given to you when you are not at the dialysis facility. Also, you can let us know if you authorize anyone else such as a family member or friend to get confidential medical information about you.

Please let us know how you want us to contact you if we are phoning you or mailing you information.

Phone Call

- ☐ OK to leave detailed message
- ☐ Leave call back number only
- ☐ Messages may be left with

____

____

____

Written Communication

- ☐ OK to mail to my home address
- ☐ Other – please describe

____

____

____
Patient Signature

____
Date

Release of Medical Records Authorization

Patient Name: ____

Date of Birth: __________________SS#:______________________________

I hereby authorize the release of my medical records to:

Spalding County Dialysis
1570 Williamson Road
Griffin, Ga. 30224
770-467-8116 Phone
770-467-8795 Fax

Please fax the following medical records:

- ☐ CMS 2728
- ☐ History & Physical
- ☐ Dialysis Short Term Care Plan
- ☐ Dialysis Long Term Care Plan
- ☐ EKG
- ☐ Chest X-Ray
- ☐ Lab Reports for the past month
- ☐ Insurance Information and copy of insurance ID card (front & back)
- ☐ Dialysis Flow Sheets for the past three treatments
- ☐ Hospital Discharge Summary
- ☐ Operative Report
- ☐ Other (Specify)

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Please contact me if any questions concerning the release of my medical records.

____________________________________	______________________________
Patient Signature	Date
____________________________________	______________________________
Daytime Phone Number	Evening Phone Number