RENAL SERVICES OF TOLEDO, INC.
HERBERT STOCKARD, M.D., AKINFEMI AFOLABI, M.D., FACP
DAVID DA ROCHA-AFODU, MD
HYPERTENSION - NEPHROLOGY
NAVARRE MEDICAL PLAZA
2702 NAVARRE AVE., SUITE 201
OREGON, OHIO 43616
(419) 698-8560
(419) 698-8570

We are looking forward to seeing you for your first appointment with our office on:

____

Please arrive at least 15 minutes before your scheduled appointment time in order to complete initial paperwork. In efforts to save time and to be more thorough, we ask that you complete the enclosed informational sheets prior to your visit. If applicable, you will find an authorization for the release of medical records that should be filled out and sent to the physician referring you to our office.

In addition, **please bring your health insurance cards and photo ID with you.** If your insurance requires a referral from your primary care physician, make sure it has been done **BEFORE** your appointment. If you receive a written confirmation, **BRING IT WITH YOU.** If you have not received it by mail, please call your insurance company and get the **AUTHORIZATION NUMBER** and bring it with you. If you do not have an authorization number, the doctor will not be able to see you since insurance won't pay if it's not authorized. **CO-PAYS WILL BE PAYABLE THE DAY OF YOUR VISIT.**

We have attached a blood work order for you to take to the lab that you are able to go through your insurance. This test is not fasting. Please have done 7 days prior to your appointment.

Please bring all your medications in the original pharmacy bottles as well as an updated list.

You will be asked to give a urine specimen in the office, so please come with a full bladder.

If you find you are unable to keep your appointment, we would appreciate it if you would call 24 hours prior to the time you are scheduled to be in the office.

Please do not hesitate to contact the office if you have any questions or concerns.

Sincerely,

Drs. Akinfemi Afolabi and David Da Rocha-Afodu

PATIENT INFORMATION

____
Date

Patient Name:____
(Last) (First) (Middle)

Address:____
(Street No./Apt. No) (City/State) (Zip/County)
Marital Status: ____Married _____Divorced_____Single_____Widow
Home Phone: ( )________-_________ Cell Phone: ( )_________-__________
Date of Birth: __________ Age:__________ Sex: ___Male___Female Race:___________
Social Security Number: ___________-_________-____________

Employer:____ ( )______-____________
(Name/Address) (Phone)
Occupation:____ Retired?_______________

Spouse's Name:____
Spouse's Address (if different)_____________________________________
Next of Kin:____
(Name/Address/Phone)

How Related?____

Referring Physician:____
(Name/Address/Phone)

INSURANCE INFORMATION

Medicare:____
Medicaid ID No.:____________________________(Part B) Effective Date:________
Reason/Medicare: ____Age _____Disability _____End Stage Renal Disease
Is Medicare your primary insurance? ___Yes ___No If no, please explain:____
____

Group Health Insurance: (Patient or thru Spouse?)______________________________
Insurance:____
(Name/Address/Phone)
Policy No.:___________________________ Group No.:______________________________
Name of Group (Employer):____
Effective Date:__________________________ PreCert/Prior Auth. Phone:_____________

Medicaid (Welfare):____
Policy No. (as appears on card):____
Effective Date:______________________PreCert/Prior Auth. Phone;________________
Caseworker's Name/Phone/County:____

Other Insurance: ___Workers Comp ___Auto ____Veterans ____Black Lung

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Note: Insurance cards must be shown to the Business Office in order for your claims to be processed correctly. Thank you.

RENAL SERVICES OF TOLEDO, INC.

NAME:_______________________________________TODAY'S DATE:________________

REFERRING PHYSICIAN_________________________ DOB:________________________

Briefly state the reasons for your visit here today:_______________________________________

____

Circle any symptoms that pertain to you:

Trouble urinating	Painful urination	stones
Blood in your urine	urinary infections	Nighttime urination
Leg swelling	Shortness of Breath	

Urine leakage when you cough/sneeze/laugh or can't get to the bathroom in time.

Other:____

PAST MEDICAL HISTORY

Have you had:

Diabetes	No	Yes
High blood pressure	No	Yes
Cancer	No	Yes
Heart trouble	No	Yes
Arthritis or gout	No	Yes
Convulsions	No	Yes
Bleeding tendency	No	Yes
Venereal disease	No	Yes
Hereditary defects	No	Yes

Prior surgery or hospitalizations: When?

____

____

____

____

Medications:

____

____

____

Allergies:____

IMMUNIZATIONS: Small Pox__Measles__Mumps__Rubella__Polio__Diptheria__Whooping Cough__

CHILDHOOD ILLNESS: Measles__Mumps__Chicken Pox__Whooping Cough__
Rheumatic Heart Fever__Scarlet Fever__Polio__Frequent Strep Throats__
Have you had a tetanus shot within the past 5 years?___

SOCIAL HISTORY (circle all that pertain to you): Are you a Jehovah's Witness? No Yes

Marital status: Unmarried Married Separated Divorced Widowed
Alcohol use: Never Rarely Moderate Daily
Tobacco use: Never How many packs you smoke___/___ I Quit (what year)
Excessive exposure at home or work to: Fumes Dust Solvents Noise Air-borne particles
Height: Any broken bones:

FAMILY HISTORY:

	Age	Diseases	If Deceased, Cause of Death
Father	____	________________________	______________________________
Mother	____	________________________	______________________________
Siblings	____	________________________	______________________________
	____	________________________	______________________________
	____	________________________	______________________________
Spouse	____	________________________	______________________________
Children	____	________________________	______________________________
	____	________________________	______________________________
	____	________________________	______________________________

PLEASE CIRCLE YES OR NO TO EACH QUESTION

*CONSTITUTIONAL SYMPTOMS
GOOD HEALTH NO YES
WEIGHT LOSS OR GAIN NO YES
FATIGUE NO YES

*EYES
VISION LOSS NO YES
GLAUCOMA NO YES
CATARACTS NO YES

*EYES, NOSE, THROAT, MOUTH
HEARING LOSS/HEARING AID NO YES
SINUSITIS NO YES
NOSE BLEEDS NO YES
SWOLLEN NECK GLANDS NO YES

*CARDIOVASCULAR
IRREGULAR RATE NO YES
PACEMAKER NO YES
MITRAL VALVE PROLAPSE NO YES
VALVE REPLACEMENT NO YES
BYPASS SURGERY NO YES
ANGINA OR CHEST PAIN NO YES
HEART ATTACK NO YES
WHEN? ___________

*RESPIRATORY
ASTHMA NO YES
EMPHYSEMA NO YES
BRONCHITIS NO YES
TUBERCULOSIS NO YES

*GASTROINTESTINAL
HEPATITIS OR LIVER DISEASE NO YES
ULCERS NO YES
GALLLBLADDER DISEASE NO YES
CANCER NO YES
LOSS OF APPETITE NO YES
CHANGE IN BOWEL HABITS NO YES

*FOR WOMEN ONLY
DATE OF LAST PERIOD _______________
HOW MANY PREGNANCIES _______________
HOW MANY BIRTHS _______________
MENSES IS REGULAR NO YES
HAVE HAD MENOPAUSE NO YES
HYSTERECTOMY NO YES

*FOR MEN ONLY
IMPOTENCY NO YES
HOW MANY MONTHS/YRS _____________
TOTAL OR PARTIAL IMPOTENCE __________
CURVED PENIS NO YES
LOSS OF DISIRE FOR SEX NO YES
OTHER MALE PROBLEMS NO YES
LISTED________________
____
____

*MUSCULOSKELETAL
JOINT PAIN/STIFFNESS NO YES
JOINT REPLACEMENT NO YES
FIBROMYLAGIA NO YES
ARTHRITIS NO YES
RHEUMATOID NO YES
OSTEOARTHRITIS NO YES

*INTEGUMENT (SKIN AND BREAST)
BREAST CANCER NO YES
VARICOSE VEINS NO YES
SKIN CANCER NO YES
RASHES NO YES

*NEUROLOGIC
SEIZURES NO YES
DISK DISEASE NO YES
PARALYSIS NO YES
MULTIPLE SCLEROSIS NO YES
PARKINSONISM NO YES
STROKE NO YES
WHEN? _______________

*PSYCHIATRIC
DEPRESSION NO YES
ALZHEIMER'S DISEASE NO YES
UNDER CARE OF PSYCHIATRIST NO YES

*BLOOD DISORDERS
ARE YOU A BLEEDER NO YES
ANEMIA NO YES
PHLEBITIS NO YES
TRANSFUSTIONS IN THE PAST NO YES
OTHER________________________________
____

*ENDOCRINE
THYROID DISEASE NO YES
DIABETES NO YES
HORMONE DISEASE NO YES
WEIGHT PROBLEM NO YES

*ALLERGIC REACTIONS
PENCILLIN NO YES
SULFA NO YES
ASPRIN NO YES
IODINE/X-RAY DYE NO YES
MORPHINE/DEMEROL/NARCOTIC NO YES
ANTIBIOTICS___________________________
____
FOOD ALLERGIES_______________________
____
____

*ANY DISEASE NOT
____
____

Patient Authorization for Disclosure of Protected Health Information
Please print all information, then sign and date form at bottom.

Type of Authorization: Release of protected health information to designated persons

Patient Name (please print)____

Purpose of request - I authorize Renal Services of Toledo, Inc. to disclose the following protected health information about me to the person(s) identified below. (Please provide a written description of the information to be disclosed):

Any and all medical information including: test results, appointments, medicine and treatment changes.

Purpose of disclosure - (Please list the purpose of the disclosure)

____
Name of Designated Person

____
Name of Designated Person

____
Name of Designated Person

____
Name of Designated Person

____
Name of Designated Person

Expirations or termination of authorization-This authorization will remain in effect until terminated by you.

Right to revoke or terminate - As stated in our Notice of Privacy Practices, you have the right to revoke or terminate this authorization by submitting a written request to our Privacy Manager. This can be done in person or by mailing a request to:

Renal Services of Toledo, Inc.
2702 Navarre Avenue, Suite 201
Oregon, OH 43616
419-698-560
Attn: Privacy Manager

Redisclosure - We have no control over the person(s) you have listed to receive your protected health information. Therefore, your protected health information disclosed under this authorization, will no longer by protected by the requirements of the Privacy Rule and will no longer be the responsibility of <u>RENAL SERVICES OF TOLEDO, INC., Dr. Afolabi, Dr. Da Rocha-Afodu and Dr. Stockard</u>

____
Patient Signature　　　　　　　　　　　　　　　　　　　Date

RENAL SERVICES OF TOLEDO, INC.
Herbert E. Stockard, M.D., Akinfemi S. Afolabi, M.D., FACP, David Da Rocha-Afodu, M.D.
Nephrology-Hypertension
2702 Narvarre Ave. Suite 201
Oregon, Ohio 43616
(419) 698-8560
Fax: (419) 698-8570

FINANCIAL POLICY

While you are waiting to see one of the doctors, we would like to explain our billing and collection procedures. If you have any questions after reading this message, please do not hesitate to let the business office know.

Fees (charges) are assigned according to regulations from government insurance (Medicare, Medicaid, etc.) and contracts with private insurers. After insurance companies reimburse our practice or if a private pay arrangement exists, you will be notified of balances for which you are responsible. Our billing office personnel will make arrangements for payment and are available to answer any questions you may have regarding your bill. The Board of Directors for our practice determines billing policies and balance resolution.

Many patients have some form of insurance which pays for most hospital, office, and medical charges. Most insurance companies determine, by contract, what amount will be paid to the physician. If there is a difference in the amount charged by the practice and what insurance will pay, each contract states whether you are responsible for the difference or if the practice must write off the balance.

It is your obligation to make arrangements for payment of balances.

If your insurance requires a referral from your primary care physician, our office must receive this **before** your appointment. If you do not have an authorization number, the doctor will not be able to see you since the insurance company will not make payment for the visit.

Co-pays are payable the day of your visit.

If you have any questions, please feel free to contact our business office. Your signature below also authorizes consent for treatment and for our practice to release medical information to your insurance company or third party provider for payment of medical benefits provided by Renal Services of Toledo, Inc.

Thank you,

Renal Services of Toledo, Inc.

Akinfemi Afolabi, M.D., FACP , David Da Rocha-Afodu, M.D., FASN

Signature:____ Date:_______________