
43576 Washington St., Suite 100 La Quinta, CA 92253
81719 Doctor Carreon Blvd., Suite A Indio, CA 92201
LQ Phone: (760) 360-4433 Fax: (442) 300-2356
Indio Phone: (760) 347-0707 Fax: (760) 347-3378

**PATIENT INFORMATION**

Last Name _____First Name _____MI_____

Address _____City_____ ST_____ Zip_____

Home Phone ( ) _____Cell ( ) _____ M F M S W D

DOB_____SSN_____E-Mail Address: _____

Race_____Ethnicity_____Language_____

Emergency Contact_____Relationship_____

Emergency Contact Phone #_____

Pharmacy Name _____City____, ST_____

RESPONSIBLE PARTY

Name of Person Responsible for this Account _____

Relationship to Patient _____DOB_____SSN_____

Employer_____Phone#_____

City_____State_____Zip_____

**INSURANCE INFROMATION**

Primary Insurance: _____

Primary Insurance ID No.: _____Group No.: _____

Secondary Insurance: _____

Secondary Insurance ID No.: _____Group No.: _____

**ASSIGMENT OF BENEFITS**: I hereby authorize my insurance benefits to be paid to the Doctor and I acknowledge that I'm financially responsible for services that are not covered benefits. I authorize my Doctor to release any pertinent information require for the purpose of billing.

**SIGNATURE**: _____**DATE**: _____

COACHELLA VALLEY
NEPHROLOGY

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**HISTORY & PHYSICAL FORM**

Complete all of this form. If a section does not apply to you, please address it with an N/A, so we don't assume you've overlooked it.

Patient Name _____Date _____
Last, First MI

List your Main Complaint(s): _____
Describe your condition (i.e. onset, cause, etc.)

_____

_____

List the date and type of diagnostic procedures (i.e.MRI's, CT scans, X-ray's, etc.) you've had, which pertain to the condition you're being evaluated for today:

_____

_____

**MEDICAL HISTORY & REVIEW OF SYSTEMS PLEASE CIRCLE ALL THAT APPLY**

Do you or have you had any of the following?

Transmissible Disease(s): None Hepatitis A-B-C HIV TB Other _____

Neurological: Headaches Stroke Epilepsy Aneurysm Other _____

Cardiovascular: Chest Pain High Blood Pressure Heart Disease Other _____

Respiratory: Lung Disease Asthma Shortness of Breath Other _____

Are you a smoker? No Yes #of years_____ #of packs per day _____

Gastrointestinal/Abd. & Pelvis: Ulcer Hernia Hysterectomy Other _____

Musculoskeletal: MSD Arthritis Back or Neck Pain Other _____

Metabolic: Liver Disease Thyroid Disorder Bleeding Disorder Cancer

Diabetes__Meds.___Insulin Other_____

Genito_Urinary: Kidney Disease Painful Urination Freq. Urination Poss.Pregnancy
Sexual Dysfunction

Eye problems: Blindness Cataracts Glaucoma Vision Difficulty

E.N.T: Hearing Loss Deaf Swallowing Problems Nose Bleeds

Psychological: Anxiety Depression Fatigue Nervousness Other _____

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Previous Hospitalization/Surgeries (List Type and Year)

1. _____ 2. _____

3. _____ 4. _____

5. _____ 6. _____

Medications you are currently taking

1. _____ 2. _____

3. _____ 4. _____

5. _____ 6. _____

List Allergies

1. _____ 2. _____

3. _____ 4. _____

5. _____ 6. _____

Patient Social History

1. Use of alcohol_____Never_____Rarely_____Moderate_____Daily
2. Use of Drugs Type/freq._____Never
3. Sleep Habits_____
4. Exercise Habits_____
5. Diet_____
6. Sexually Related Complaints_____
7. Leisure Activities (Hobbies)_____
8. Stress Level_____

Family Medical History

| | Age | Diseases | If deceased, cause of death |
|---|---|---|---|

| | | | |
|---|---|---|---|
| Father | | | |
| Mother | | | |
| Siblings | | | |
| Spouse | | | |
| Children | | | |


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**Patient Name:** _____ **Date of Birth:** _____
First Name MI Last Name

**ASSIGNMENT OF BENEFITS:**
I hereby authorize direct payment of my insurance benefits to CVN for services rendered to me. 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 that CVN is unable to collect from my insurance carrier for whatever reason.

**MEDICARE/MEDICAID/ CHAMPUS 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 records that these programs may request. I hereby direct that payment of my authorized benefits be made directly CVN or the physicians on my behalf.

**AUTHORIZATION TO RELEASE NON-PUBLIC PERSONAL INFORMATION:**
I certify that I have received and read a copy of the CVN/VCMG, group Patient Information Privacy Policy. I hereby authorize CVN or the physician individually to release any of my 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 EMAIL:**
I certify that I understand the privacy risks of the mail, phone calls, and e-mail. I hereby authorize CVN representative or my physician to mail, calls, 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 me CVN 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.

**CONSENT TO TREATMENT:**
I hereby consent to evaluation, testing and treatment as directed by CVN physicians or his or her designee.

**PATIENT SIGANTURE: _____ DATE: _____**

**GUARANTOR SIGNATURE: _____ DATE: _____**
(If different from patient)

**GUARANTOR NAME (PLEASE PRINT): _____**

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**PERMISSION TO DISCUSS PROTECTED HEALTH INFORMATION WITH OTHERS**

I hereby grant permission to CVN to speak to the following individuals about my health and disclose my health information including billing and insurance. I understand this

authorization does not include information regarding HIV, psychiatric, drug and/or alcohol records, which must be authorized on a separate release.

**Patient Name:** _____

Spouse: _____

Children:
1. _____ 2. _____

Guardian: _____

Caregiver: _____

Sister: _____

Brother: _____

Friend: _____

Emergency Contact: _____

Other: _____

You may discuss my (please check all that apply)
☐ Visit Notes
☐ Laboratory Results
☐ X-rays
☐ Reports
☐ All Services and Treatment Rendered

**I understand that I may revoke this authorization at any time in writing.**

Patient/Guardian Signature_____Date_____

Patient Name (**print**) _____Patient Date of Birth_____