

Camilo G. Barcenas, MD FACP
Whitson B. Etheridge, MD
Eric J. Faust, MD
Salman A. Khan, MD
Robert B. Leggington, MD
Bilal Moukaddem, MD
Aashish Pandya, MD
Sibtain H. Ali, MD
Humaira K. Chaudhary, MD
Debbie Kurian, MD



Jennifer L. Finch, MD
Henry Muniz, MD
Sarah A. Shearer, MD
Katherine Timmins, MD
Jesse K. Uyeda, MD
June Yao, MD
Vijay Koka, MD
Mohammed A. Ahmed, MD
Billy R. Gilbert, MD
Brian Armentrout, PA-C

Patient's Name: _____ DOB: _____

Appointment Date: _____ Time: _____

You are scheduled to see one of the kidney doctor's at Renal Specialists of Houston, P.A. . Please take a few moments to complete the following questions and bring with you to your first visit. You should plan to arrive a few minutes early in order to complete any additional administrative paperwork. **If you arrive more than 20 minutes after your scheduled appointment time, you will be rescheduled.**

Why are you seeing a kidney doctor? (As far as you know)

What medical conditions do you have?

- High Blood Pressure: _____ Yes _____ No

If yes, how long? _____

- Diabetes: _____ Yes _____ No

If yes, how long? _____

- Heart Disease: _____ Yes _____ No

If yes, How long? _____

Any other medical conditions?

Please list any surgeries & approximate dates:

SURGERY

DATE

Do you smoke? Yes No

If no, have you ever smoked? Yes No

If yes, how many per day? _____

Do you drink alcohol? Yes No

If yes, how often? _____

What medications are you currently taking?(Please include non-prescription medications also)

Name of Medication

Dose

Frequency

List any allergies:

Pharmacy info:

Name: _____ Address: _____

Phone: _____ Fax: _____

Does anyone in your family have/had the following:

- High Blood Pressure Yes No
- Diabetes Yes No
- Kidney Disease Yes No

**Thank you in advance for completing this form.
We look forward to seeing you at you're your scheduled appointment.**

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**Renal Specialists of Houston, P.A.
renalspecialists.com**

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NAME:

AGE

DATE OF BIRTH:

SOCIAL SECURITY:

SEX:

MARTIAL STATUS:

E-MAIL:

HOME PHONE:

PAGER:

MOBILE:

ADDRESS:

CITY:

STATE:

ZIP:

EMPLOYER:

PHONE:

INSURANCE CO:

PHONE:

ID/ACCT #:

GROUP#:

INSURED:

SPOUSE'S NAME:

SOCIAL SECURITY:

DOB:

EMPLOYER:

PHONE:

NEAREST LIVING RELATIVE(not living with you):

PHONE:

RELATION TO PATIENT:

REFERRING DOCTOR:

PHONE:

PRIMARY CARE DOCTOR:

PHONE:

PHYSICIAN AUTHORIZATION AND ASSIGNMENT

I grant permission to Renal Specialists of Houston, PA to release any pertinent information to the above companies and/or government agencies. I also authorize payment of medical benefits to be paid directly to Renal Specialists of Houston, PA if

assignment of benefits is accepted for my medical/surgical services. A copy of this authorization can be used as an original for insurance purposes. I agree to be financially responsible for services fully or partially denied by my insurance company for reasons of: non-covered services under my plan benefits; experimental procedures; or procedures deemed not medically necessary by my insurance company.

SIGNATURE OF PATIENT/GUARDIAN

DATE