

BMI Nephrology Systems, Inc.

635 N. Main Street • High Point, NC 27262 • tel: 336-887-0038 • fax: 336-885-8096

Benjamin Igwemezie, MD

Diplomate in

- Nephrology
- Internal Medicine

Welcome to BMI Nephrology. We are honored that you have chosen us as your health care provider for your kidney disease, hypertension, and anemia management. Our goal is to provide the highest quality care for all of our patients in a timely and respectful manner.

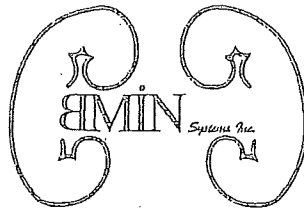
You will need to bring your insurance card with you for each appointment. Please let our staff know if you have had any information changes since your last appointment.

All co-pays and past due balances are expected at time of service, unless a prior agreement has been made with our billing department.

We ask that you allow plenty of time to get to the office for your appointment. You may be asked to reschedule your appointment if you are more than 15 minutes late. We will strive to stay on time. From time to time, a patient emergency arises and we may be running late for your visit. You will have the option to re-schedule or stay to be seen and we will keep you informed of how long of a delay you may experience.

Please bring all of your prescription and over-the-counter medications with you at each visit.

Attached are four pages of paperwork for you to complete and bring with you to your first office visit, along with your insurance cards and medications.



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635 N. Main Street • High Point, NC 27260 and 25 West Guilford Street Thomasville • tel: 336-887-0038 • fax: 336-885-8096 tel 336-475-5055 fax 336-475-5177

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Patient Information

Patient Last Name _____ First Name _____ MI _____
 Address _____
 City _____ State _____ Zip _____ Social Security Number _____ - ____ - ____
 Sex (circle one) M F Marital Status (circle one) S M W D
 Employed (circle one) Y N Retired Employer/School _____
 Home Phone # () _____ Work Phone # _____
 Date of Birth _____ Age _____ Race _____

EMERGENCY CONTACT

Name: _____ Phone Number _____
 Relationship to Patient _____

This medical practice works with its patients to minimize difficulty in the payment of fees for service. Upon leaving from your appointment, you will be asked to pay those minimal unmet deductible amounts and co-insurance amounts, which your insurance company authorizes to be collected. Further, we automatically file insurance claims with your insurance company; therefore, please insure that primary and secondary insurance information is correct.

Authorization to Release Information: The undersigned hereby authorized said Provider to release all information pertaining to patient's treatment to his/her insurance company or companies and to any other physician or health care provider to who the undersigned may be referred.

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicaid, private insurance, and other health plan to: BMI NEPHROLOGY.

Patient Signature Date

Responsible Party Relationship Date

PATIENT MEDICAL HISTORY QUESTIONNAIRE

Name _____	Date of Birth _____
Referring Physician _____	Phone Number _____
Primary Care Physician _____	Phone Number _____
Occupation _____	
Reason for Visit _____	

Are you allergic to any medications: yes/no
Please list _____
What occurs if you have a reaction: _____
Name of your pharmacy _____ City/street _____

SYMPTOMS REVIEW

Do you currently have or have you had the following in the last month.

- | | | |
|--|---|--|
| Fever <input type="checkbox"/> yes <input type="checkbox"/> no | cough <input type="checkbox"/> yes <input type="checkbox"/> no | painful urination <input type="checkbox"/> yes <input type="checkbox"/> no |
| Constipation <input type="checkbox"/> yes <input type="checkbox"/> no | Blurry vision <input type="checkbox"/> yes <input type="checkbox"/> no | shortness of breath <input type="checkbox"/> yes <input type="checkbox"/> no |
| Malaise <input type="checkbox"/> yes <input type="checkbox"/> no | Urine incontinence <input type="checkbox"/> yes <input type="checkbox"/> no | diarrhea <input type="checkbox"/> yes <input type="checkbox"/> no |
| Double vision <input type="checkbox"/> yes <input type="checkbox"/> no | Poor appetite <input type="checkbox"/> yes <input type="checkbox"/> no | wheezing <input type="checkbox"/> yes <input type="checkbox"/> no |
| Bloody urine <input type="checkbox"/> yes <input type="checkbox"/> no | Nausea <input type="checkbox"/> yes <input type="checkbox"/> no | Eye pain <input type="checkbox"/> yes <input type="checkbox"/> no |
| Headache <input type="checkbox"/> yes <input type="checkbox"/> no | Rash <input type="checkbox"/> yes <input type="checkbox"/> no | chest pain <input type="checkbox"/> yes <input type="checkbox"/> no |
| Urine retention <input type="checkbox"/> yes <input type="checkbox"/> no | vomiting <input type="checkbox"/> yes <input type="checkbox"/> no | leg cramps <input type="checkbox"/> yes <input type="checkbox"/> no |
| Seizures <input type="checkbox"/> yes <input type="checkbox"/> no | itching <input type="checkbox"/> yes <input type="checkbox"/> no | irregular heartbeat <input type="checkbox"/> yes <input type="checkbox"/> no |
| Bone pain <input type="checkbox"/> yes <input type="checkbox"/> no | joint pain <input type="checkbox"/> yes <input type="checkbox"/> no | arthritis <input type="checkbox"/> yes <input type="checkbox"/> no |
| Dizziness <input type="checkbox"/> yes <input type="checkbox"/> no | Leg swelling <input type="checkbox"/> yes <input type="checkbox"/> no | |

Do you have or are you receiving treatment for any of the following conditions:
(If you answer yes, please indicate how long ago you were diagnosed with this condition)

- | | |
|---|--|
| Anemia <input type="checkbox"/> yes <input type="checkbox"/> no | High blood pressure <input type="checkbox"/> yes <input type="checkbox"/> no |
| Bone/Joint Pain <input type="checkbox"/> yes <input type="checkbox"/> no | High cholesterol <input type="checkbox"/> yes <input type="checkbox"/> no |
| Cancer <input type="checkbox"/> yes <input type="checkbox"/> no
What type? _____ | Kidney Disease <input type="checkbox"/> yes <input type="checkbox"/> no |
| Diabetes <input type="checkbox"/> yes <input type="checkbox"/> no | Kidney Stone <input type="checkbox"/> yes <input type="checkbox"/> no |

Gout yesno

Lung Disease yesno

Heart Disease yesno

Proteinuria yesno

Hematuria yesno

Seizures yesno

FAMILY HISTORY

Anybody in your family with the following diseases

High blood Pressure yesno

Diabetes yesno

Heart diseaseyesno

Kidney disease yesno

kidney stone yesno

cancer yesno

Electrolyte abnormalities yesno

SOCIAL HISTORY

SMOKING

YES

NO

IF YES: HOW MANY YEARS _____

HOW MANY A DAY _____

ALCHOL USE

YES

NO

IF YES: HOW MANY YEARS _____

HOW MANY A DAY _____

ILLCIT DRUGS

YES

NO

MARITIAL STATUS

MARRIED

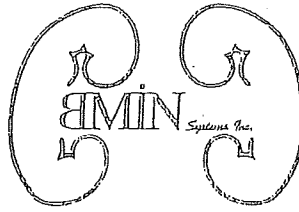
SINGLE

DIVORCED

SEPERATED

WIDOWED

EMPLOYMENT _____



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Ikechikwu Nwobu, MD

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Acknowledgement of Receipt of Notice of Privacy Practices
BMI Nephrology Systems, Inc reserves the right to modify the privacy practices outlined in the notice.

Signature

I have received a copy of the Notice of Privacy Practices for BMI Nephrology Systems, Inc.

Name of Patient

Signature of Patient

Date

Signature of Patient Representative

(Required if the patient is a minor or an adult who is unable to sign this form)

Relationship of Patient Representative to Patient