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 QUESTIONAIRE

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 ☐yes ☐no	cough ☐yes ☐no	painful urination ☐yes☐no
Constipation ☐yes ☐ no	Blurry vision ☐yes ☐no	shortness of breath ☐yes ☐no
Malaise ☐yes ☐no	Urine incontinence ☐yes ☐no	diarrhea ☐yes ☐no
Double vision ☐yes ☐no	Poor appetite ☐yes ☐no	wheezing ☐yes ☐no
Bloody urine ☐yes ☐no	Nausea ☐yes ☐no	Eye pain ☐yes ☐no
Headache ☐yes ☐no	Rash ☐yes ☐no	chest pain ☐yes ☐no
Urine retention ☐yes ☐no	vomiting ☐yes ☐no	leg cramps ☐yes ☐no
Seizures ☐yes ☐no	itching ☐yes ☐no	irregular heartbeat ☐yes ☐no
Bone pain ☐yes ☐no	joint pain ☐yes ☐no	arthritis ☐yes ☐no
Dizziness ☐yes ☐no	Leg swelling ☐yes ☐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 ☐yes ☐no	High blood pressure ☐yes ☐no
_____	_____
Bone/Joint Pain ☐yes☐no	High cholesterol ☐yes☐no
_____	_____
Cancer ☐yes☐no	Kidney Disease ☐yes☐no
What type?_____	_____
Diabetes ☐yes☐no	Kidney Stone ☐yes☐no
_____	_____

Gout ☐yes☐no

Heart Disease ☐yes☐no

Hematuria ☐yes☐no

Lung Disease ☐yes☐no

Proteinuria ☐yes☐no

Seizures ☐yes☐no

FAMILY HISTORY
Anybody in your family with the following diseases

High blood Pressure ☐yes☐no Diabetes ☐yes☐no Heart disease☐yes☐no

Kidney disease ☐yes☐no kidney stone ☐yes☐no cancer ☐yes☐no

Electrolyte abnormalities ☐yes☐no

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 _____

ILLICIT DRUGS ☐ YES ☐ NO

MARITIAL STATUS ☐ MARRIED
☐ SINGLE
☐ DIVORCED
☐ SEPERATED
☐ WIDOWED

EMPLOYMENT _____

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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