



Paul A. Parker, M.D.	Michael C. Akom, M.D.	Michael G. Tranfaglia, PA-C
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John P. Vella, M.D., FACP,FRCP,FASN	Ana Rossi, M.D., MPH	Sara E. Rosa, PA-C
Robert F. Zimmerman III, M.D.	Gary DiPerna, D.O.	Lisa Hutter, R.D.
Stuart Abramson, M.D.	Mahendra Mangray, M.D.	

Dear _____, welcome to our practice!

Maine Nephrology Associates is a group practice limited to the care of patients with kidney disease and hypertension. You have been referred for a consultation with:

Dr. _____ on: _____ at: _____

During your initial office visit, the physician will perform a comprehensive history and physical examination. **Upon arrival, you will be asked to provide a urine sample for analysis and blood may be drawn at the end of the visit.** Since Maine Nephrology Associates has a close relationship with the teaching program at Maine Medical Center, a physician participating in the Nephrology Fellowship Program may also be involved with your care.

Enclosed, you will find our **Patient Information Sheet, Patient Medical History Form, and Patient Care Team Form.** Please complete and/or sign these forms and send back to us in the stamped envelope we have provided no later than **5 business days** before your scheduled consultation appointment.

On the day of your appointment, please bring with you your **insurance cards, drug coverage cards, updated list of medications,** and a **photo ID.** If your insurance company requires a referral, please contact your Primary Care Physician.

We hope this information is helpful to you. If you find that you are unable to come to this appointment, please notify the office at least **48 hours prior to appointment.** When you give the office proper cancellation notice, the scheduling staff has an opportunity to offer the appointment to someone else. If you have any questions, please don't hesitate to contact us at (207) 774- 5222.

Thank you and we look forward to seeing you.

Scheduling Coordinator

PRACTICE LIMITED TO KIDNEY DISEASE AND HYPERTENSION

1600B Congress Street Portland, ME 04102 | Tel: (207) 774-5222 Fax: (207) 761-4433

www.mainenephrology.com



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Directions To Maine Nephrology Associates Portland

From Northern Maine: Drive South on Route 295 and take Exit 5B (Congress Street West). At the end of the ramp, go right at the traffic light onto Congress Street. Continue straight through four traffic lights and go over the railroad tracks. At the next (fifth) traffic light, turn left into our parking lot. We are located at 1600B Congress Street.

From Southern Maine: Drive north on Route 295 to Exit 5 (Congress Street). The ramp splits, bear right and at the second light turn left onto Congress Street / Route 22 West. Continue through four traffic lights and go over the railroad tracks. At the next (fifth) traffic light, turn left into our parking lot. We are located at 1600B Congress Street.

From the Maine Turnpike, both North and South: Take Exit 46 (formerly Exit 7A) and after proceeding through the toll booth, take a right at the light. At the next traffic light, take a left onto Johnson Road, which will become Congress Street. Continue straight through three traffic lights and at the fourth light take a right into our parking lot. We are located at 1600B Congress Street.

From Route 302: Travel south on 302 to the Portland Intersection (Morrill's Corner) where you pass McDonald's on the right. At the next fork in the road, bear right onto Stevens Avenue. Travel to the end of Stevens Avenue and take a right onto Congress Street. Continue straight on Congress Street and go over the railroad tracks. At the next traffic light, turn left into our parking lot. We are located at 1600B Congress Street.

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October 1, 2018

Dear Patient:

Today we have exciting news regarding your health management!

As we continue in our efforts to provide our patients with the highest quality of care, we are constantly looking for methods of working together with you to ensure that you are not only aware of, but also involved in the management and improvement of your health.

We are proud to inform you that our practice offers the opportunity to use the power of the web to track the most important aspects of your healthcare through our office. The Patient Portal enables our patients to communicate with our doctors, nurses, and staff members easily, safely, and securely via the Internet.

Participating patients are given secure User IDs and passwords, enabling them to access the Portal to view their personal and private documents, including lab and diagnostic test results, educational information, billing statements, and other health information.

Through the Patient Portal, you are able to:

- ask questions of doctors, nurses, and staff members
- request prescription refills and referrals
- view your personal health record
- examine your current and past statements

... all from the comfort of your home, whenever it is convenient for you!

By using the Patient Portal, you no longer have to call the office, leave a message, and wait for a response to get the results of your lab work; those results will be available to you through the Portal. You can also send a message to the office through the Portal and expect a prompt reply.

To learn more, contact our office today at 207-774-5222. To sign up, please provide your email on the enclosed Patient Information form.

Begin today to take an active role in managing your healthcare!

Yours truly,

Maine Nephrology Associates Team

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PATIENT INFORMATION

NAME: _____ Social Security _____

Sex: ___M___F Date of Birth: _____ Email: _____

Mailing Address: _____
(No. & Street)

(City, State, Zip Code)

Home Phone: _____ Other (e.g., cell) Phone: _____

Employer: _____ Work Phone: _____

EMERGENCY CONTACT:

Name: _____ Relationship: _____ Phone: _____

PRIMARY CARE PHYSICIAN: _____ Phone: _____

Address: _____

INSURANCE CO. NAME: Primary _____ ID#: _____

Secondary: _____ ID#: _____

(MNA will make a photo copy of your insurance cards and drug coverage cards.)

PHARMACY: _____ TOWN: _____ STATE: _____

Authorizations and Consents

Authorizations for Treatment:

I authorize diagnostic procedures and medical care as necessary in the judgment of my doctor.

Payment: I understand that I am responsible for the payment of the health care services furnished to me by MNA even though I may be covered under an insured or other health plan arrangement. I authorize MNA to receive payment of benefits from an insurer, managed care organization, governmental agency or other third party payor that is responsible for payment or for arranging payment of the health care services provided to me by MNA.

SIGNED: _____ Date: _____

____ Patient or ____ Patient Representative

Note: Some medical insurance policies require prior authorization for medical services we may perform or refer you for. It is your responsibility to follow your company's guidelines for proper reimbursement, but our office staff will be happy to assist you.

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Name: _____ Date of Birth: _____

We want to make sure that all our patients receive the best care possible. In support of that goal, The Affordable Care Act promotes data collection regarding race, ethnicity and language. You have the option to provide answers to the following questions. Every response will be confidential.

DO YOU CONSIDER YOURSELF HISPANIC OR LATINO?

- Yes
- No
- Unavailable/Unknown
- Declined

WHICH CATEGORY BEST DESCRIBES YOUR RACE?

- American Indian or Alaska Native
- Asian
- Native Hawaiian or Other Pacific Islander
- Black or African American
- White or Caucasian
- Other Race
- Unavailable or Unknown
- Declined

WHAT LANGUAGE DO YOU FEEL MOST COMFORTABLE SPEAKING WITH YOUR DOCTOR, NURSE OR CLINICAL ASSISTANT?

- English
- French
- Spanish
- Indian (including Hindi & Tamil)
- Arabic
- Farsi
- Chinese
- Croatian
- German
- Japanese
- Somali
- Sign Language
- Other: _____

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Date: _____

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Name: _____ DOB: _____

Current Medications: (Please feel free to attach your own list)

Please Place X in Appropriate Box

Medication	Dose	AM	NOON	PM

Are you presently taking any of the following medications (check all that you are taking):

- | | |
|---|--|
| <input type="checkbox"/> Aspirin, Bufferin, Anacin | <input type="checkbox"/> Weight reduction pills |
| <input type="checkbox"/> Lotions or Creams | <input type="checkbox"/> Hormones |
| <input type="checkbox"/> Cough medicine | <input type="checkbox"/> Antibiotics |
| <input type="checkbox"/> Shots (B ₁₂ , allergy, etc.) | <input type="checkbox"/> Birth control pills |
| <input type="checkbox"/> Insulin or diabetic pills | <input type="checkbox"/> Tums/Mylanta/Roloids |
| <input type="checkbox"/> Iron or poor blood medications | <input type="checkbox"/> Aleve, Advil, ibuprofen, Celebrex |
| <input type="checkbox"/> Laxatives | <input type="checkbox"/> Over the counter medications |
| <input type="checkbox"/> Sleeping pills | <input type="checkbox"/> Vitamins |
| <input type="checkbox"/> Tylenol (acetaminophen) | <input type="checkbox"/> Herbal supplements |
| <input type="checkbox"/> Other medications not listed above _____ | |

DRUG ALLERGIES (drug and reaction): _____

Name and date of any operations which you have had: _____

Serious injuries or accidents which you have had (and date(s), if known): _____

Illnesses requiring hospitalization (and date(s), if known): _____

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Social History:

	<u>Yes</u>	<u>No</u>
Do you smoke? Cigarettes	<input type="checkbox"/>	<input type="checkbox"/>
Pipe	<input type="checkbox"/>	<input type="checkbox"/>
Cigar	<input type="checkbox"/>	<input type="checkbox"/>
If yes, for how many years? _____		
Have you ever smoked any of the above in the past?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, for how many years? _____		
Do you drink coffee?	<input type="checkbox"/>	<input type="checkbox"/>
How many cups per day? _____		
Do you regularly drink alcohol?	<input type="checkbox"/>	<input type="checkbox"/>
How much per day? 1 oz <input type="checkbox"/> 2 oz <input type="checkbox"/> 4 oz <input type="checkbox"/> over 6 oz <input type="checkbox"/>		
Beer: 1 bottle/day <input type="checkbox"/> 2 bottles/day <input type="checkbox"/> 4+ bottles/day <input type="checkbox"/>		
Do you have difficulty falling asleep?	<input type="checkbox"/>	<input type="checkbox"/>
Do you exercise?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, what type and how often _____		

Marital Status: Married _____ Divorced _____ Single _____ Widowed _____

Work Status:

What type of work do you do? _____
 Retired? _____ If yes, how long? _____
 Disability? _____

Who is your support system? _____

Please check "Yes" to any that apply now or in the past:

	<u>Yes</u>	<u>No</u>
A. <u>Exposure to infections:</u>		
TB	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis B	<input type="checkbox"/>	<input type="checkbox"/>
C	<input type="checkbox"/>	<input type="checkbox"/>
B. <u>Immune compromise (weakened immune system)</u>	<input type="checkbox"/>	<input type="checkbox"/>
C. <u>Symptoms currently/recently:</u>		
Fever	<input type="checkbox"/>	<input type="checkbox"/>
Loss of appetite	<input type="checkbox"/>	<input type="checkbox"/>
Weight loss	<input type="checkbox"/>	<input type="checkbox"/>
Weight gain	<input type="checkbox"/>	<input type="checkbox"/>
Night sweats	<input type="checkbox"/>	<input type="checkbox"/>
D. <u>Neurologic System</u>		
Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Mini-stroke	<input type="checkbox"/>	<input type="checkbox"/>
Seizure	<input type="checkbox"/>	<input type="checkbox"/>
Numbness or pain in feet or hands	<input type="checkbox"/>	<input type="checkbox"/>
Restless legs	<input type="checkbox"/>	<input type="checkbox"/>

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		<u>Yes</u>	<u>No</u>
E.	<u>Ear/Nose/Throat</u>		
	Do you have hearing loss?	<input type="checkbox"/>	<input type="checkbox"/>
	Sore throat	<input type="checkbox"/>	<input type="checkbox"/>
	Hoarseness	<input type="checkbox"/>	<input type="checkbox"/>
	Nose bleeds	<input type="checkbox"/>	<input type="checkbox"/>
	Nasal Congestion	<input type="checkbox"/>	<input type="checkbox"/>
F.	<u>Pulmonary/Lung</u>		
	Asthma	<input type="checkbox"/>	<input type="checkbox"/>
	Shortness of breath		
	- with exertion	<input type="checkbox"/>	<input type="checkbox"/>
	- when lying flat	<input type="checkbox"/>	<input type="checkbox"/>
	Cough	<input type="checkbox"/>	<input type="checkbox"/>
	Phlegm	<input type="checkbox"/>	<input type="checkbox"/>
G.	<u>Stomach/Intestine</u>		
	Nausea/Vomiting	<input type="checkbox"/>	<input type="checkbox"/>
	Black bowel movements	<input type="checkbox"/>	<input type="checkbox"/>
	Bloody bowel movements	<input type="checkbox"/>	<input type="checkbox"/>
	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>
	Constipation	<input type="checkbox"/>	<input type="checkbox"/>
	Cirrhosis	<input type="checkbox"/>	<input type="checkbox"/>
	History of hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
H.	<u>Genito-urinary</u>		
	Do you have?		
	Burning when urinating	<input type="checkbox"/>	<input type="checkbox"/>
	Loss of control of bladder	<input type="checkbox"/>	<input type="checkbox"/>
	Blood in the urine	<input type="checkbox"/>	<input type="checkbox"/>
	Prostate problem	<input type="checkbox"/>	<input type="checkbox"/>
	Trouble starting to urinate	<input type="checkbox"/>	<input type="checkbox"/>
	Getting up frequently at night to urinate	<input type="checkbox"/>	<input type="checkbox"/>
	Have you ever passed a kidney stone?	<input type="checkbox"/>	<input type="checkbox"/>
J.	<u>Musculoskeletal</u>		
	Do you have?		
	Joint pain	<input type="checkbox"/>	<input type="checkbox"/>
	Muscle pains	<input type="checkbox"/>	<input type="checkbox"/>
	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>
	Leg cramps	<input type="checkbox"/>	<input type="checkbox"/>
K.	<u>Cardiovascular (heart and blood vessel)</u>		
	Chest pain or chest heaviness	<input type="checkbox"/>	<input type="checkbox"/>
	Heart palpitations	<input type="checkbox"/>	<input type="checkbox"/>
	Swelling in your ankles/shins	<input type="checkbox"/>	<input type="checkbox"/>
	Varicose veins	<input type="checkbox"/>	<input type="checkbox"/>
	Heart attack	<input type="checkbox"/>	<input type="checkbox"/>
L.	<u>Skin</u>		
	Rashes	<input type="checkbox"/>	<input type="checkbox"/>
	Psoriasis	<input type="checkbox"/>	<input type="checkbox"/>
	Eczema	<input type="checkbox"/>	<input type="checkbox"/>
	Skin Cancer	<input type="checkbox"/>	<input type="checkbox"/>

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- M. Hematologic (blood)
 Have you ever had?
 Easy bruising
 Anemia
 Excessive bleeding
- N. Psychiatric
 Depression
 Anxiety
 Bipolar disease
 Mania
 Other
- O. Reproductive System/Sexual Function
- Women:
 Regular monthly menstrual periods?
 Date of last menstrual period _____
 Do you regularly have mammograms?
 Date of last test: _____
 Do you regularly have PAP smears?
 Date of last test: _____
 How many children born alive _____
 Miscarriages _____
 Stillbirths _____
 Cesarean operations: _____
 Premature births: _____
- Any complications of pregnancy
 Treatment for genital infections
- Men:
 Erectile dysfunction
 Genital infections
 Hernia

FAMILY HISTORY:

Family Member	Age	Sex	Health	If Deceased, Age at Death And Cause
Father				
Mother				
Siblings				
Spouse				
Children				

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Do you know of any blood relative who has or has had:

<u>Condition</u>	<u>Relationship</u>
<input type="checkbox"/> Arthritis	_____
<input type="checkbox"/> Asthma	_____
<input type="checkbox"/> Bleeding tendency	_____
<input type="checkbox"/> Cancer	_____
<input type="checkbox"/> Colitis	_____
<input type="checkbox"/> Congenital heart problems	_____
<input type="checkbox"/> Diabetes	_____
<input type="checkbox"/> Epilepsy	_____
<input type="checkbox"/> Goiter	_____
<input type="checkbox"/> Hay fever	_____
<input type="checkbox"/> Heart attack	_____
<input type="checkbox"/> High blood pressure	_____
<input type="checkbox"/> Kidney disease	_____
<input type="checkbox"/> Leukemia	_____
<input type="checkbox"/> Mental Health Issues	_____
<input type="checkbox"/> Migraines	_____
<input type="checkbox"/> Rheumatic heart disease	_____
<input type="checkbox"/> Stomach ulcers	_____
<input type="checkbox"/> Stroke	_____

Please provide us with any other information that you may feel will be helpful to us:
