Maine Nephrology Associates

Paul A. Parker, M.D.
James C. Wasserman, M.D.
Patricia L. Cantlin, D.O.
John P. Vella, M.D., FACP,FRCP,FASN
Robert F. Zimmerman III, M.D.
Stuart Abramson, M.D.
Michael C. Akom, M.D.
Eric N. Taylor, M.D., MSc
Ioan Mihai Cosma, M.D.
Ana Rossi, M.D., MPH
Gary DiPerna, D.O.
Mahendra Mangray, M.D.
Michael G. Tranfaglia, PA-C
Eric D. Holmes, PA-C
Emily Snow, FNP
Sara E. Rosa, PA-C
Elizabeth Whitney, PA-C
Lisa Hutter, R.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.** Make sure to complete front and back on all forms, sign where applicable, 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

***Continued on the back***

# 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.

***Continued on the back***

Maine Nephrology Associates



NAME: _____ DOB:_____

# PATIENT CARE TEAM

*Please list all doctors who are currently involved in your treatment plan (within the last two years) so that we may update them on your visit with us.*

| SPECIALTY | PROVIDER NAME | TOWN/STATE |
|---|---|---|
| PRIMARY CARE | | |
| CARDIOLOGIST | | |
| ONCOLOGIST | | |
| HEMATOLOGIST | | |
| ENDOCRINOLOGIST/DIABETES | | |
| RHEUMATOLOGIST | | |
| UROLOGIST | | |
| OTHER | | |
| OTHER | | |
| OTHER | | |
| OTHER | | |

***Continued on the back***

Maine Nephrology Associates



January 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 Healthcare Team

***Continued on the back***

Maine Nephrology Associates



## 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.*

***(Continued on the back)***

Maine Nephrology Associates



**NAME:** _____ **DOB:**_____

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: _____

***Continued on the back***

Maine Nephrology Associates



**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):

- ☐ Aspirin, Bufferin, Anacin
- ☐ Lotions or Creams
- ☐ Cough medicine
- ☐ Shots ($B_{12}$, allergy, etc.)
- ☐ Insulin or diabetic pills
- ☐ Iron or poor blood medications
- ☐ Laxatives
- ☐ Sleeping pills
- ☐ Tylenol (acetaminophen)
- ☐ Weight reduction pills
- ☐ Hormones
- ☐ Antibiotics
- ☐ Birth control pills
- ☐ Tums/Mylanta/Rolaids
- ☐ Aleve, Advil, ibuprofen, Celebrex
- ☐ Over the counter medications
- ☐ Vitamins
- ☐ Herbal supplements
- ☐ 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):_____

_____

Other illnesses/conditions (and date(s), if known): _____

_____

***Continued on the back***

Maine Nephrology Associates

**Page 8**

| Social History: | | Yes | No |
|---|---|---|---|
| Do you smoke? | Cigarettes | ☐ | ☐ |
| | Pipe | ☐ | ☐ |
| | Cigar | ☐ | ☐ |

If yes, for how many years? _____

Have you ever smoked any of the above in the past? ☐ ☐

If yes, for how many years? _____

Do you drink coffee? ☐ ☐

How many cups per day?_____

Do you regularly drink alcohol? ☐ ☐

How much per day? 1 oz☐ 2 oz☐ 4 oz☐ over 6 oz☐

Beer: 1 bottle/day☐ 2 bottles/day☐ 4+ bottles/day☐

Do you have difficulty falling asleep? ☐ ☐

Do you exercise? ☐ ☐

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:

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

***Continued on the back***

Maine Nephrology Associates



**NAME:** _____ **DOB:**_____

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

***Continued on the back***

Maine Nephrology Associates



| | | Yes | No |
|---|---|---|---|
| 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 | | | | |
| | | | | |
| | | | | |
| | | | | |

***Continued on the back***

Maine Nephrology Associates



**NAME:** _____ **DOB:**_____

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

| Condition | Relationship |
|---|---|
| ☐ Arthritis | _____ |
| ☐ Asthma | _____ |
| ☐ Bleeding tendency | _____ |
| ☐ Cancer | _____ |
| ☐ Colitis | _____ |
| ☐ Congenital heart problems | _____ |
| ☐ Diabetes | _____ |
| ☐ Epilepsy | _____ |
| ☐ Goiter | _____ |
| ☐ Hay fever | _____ |
| ☐ Heart attack | _____ |
| ☐ High blood pressure | _____ |
| ☐ Kidney disease | _____ |
| ☐ Leukemia | _____ |
| ☐ Mental Health Issues | _____ |
| ☐ Migraines | _____ |
| ☐ Rheumatic heart disease | _____ |
| ☐ Stomach ulcers | _____ |
| ☐ Stroke | _____ |

Any other information that you may feel will be helpful to us:

| |
|---|
| |
| |
| |
| |
| |
| |
| |
| |