COMPASSIONATE KIDNEY CARE INC

7351 W. Oakland Park Blvd Suite 105
Lauderhill, FL 33319-7107
Phone: 954-908-5992 Patient Related Fax: 954-951-1171

New Patient Pre-office Registration

DATE _____

Have you been seen at Compassionate Kidney Care or by Dr. John before? ☐ No ☐ Yes — approximate year: _____

***PATIENT REGISTRATION**

Patient's Last Name	First Name	M.I.	Date of Birth	Sex at Birth

Street Address	City	State	ZIP	County

Cell Phone	Home Phone	Email Address

Preferred Language	Race / Ethnicity	How did you hear about Compassionate Kidney Care?

***Emergency Contact**

Emergency Contact Name	Relationship	Phone Number

☐ Enroll in Elation Health Portal to access records online	☐ Send findings and treatment plan to my PCP
☐ Authorize physician to view Rx E-prescriptions	☐ Authorize electronic prescribing

Preferred Pharmacy 1 — Name	Phone	Address

Pharmacy 2 — Name (if applicable)	Phone	Address

***What is the main problem/concern that need to be evaluated?** _____

Seen prior Nephrologist? ☐ No ☐ Yes **If so, who?** _____ — approximate year: _____

Is he/she aware patient switching nephrologist? _____

Patient to obtain medical Records prior to arrival in order to have a meaningful visit.

COMPASSIONATE KIDNEY CARE INC

FINANCIAL AUTHORIZATION AND POLICIES

Section 1 — Medicare and Insurance Authorization

I certify that the information given in applying for payment under Title XVII of the Social Security Act is correct. I authorize any holder of medical information about me to release to the Social Security Administration or its intermediaries any information needed for this or any related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign benefits payable for physician services to the physician or organization furnishing the services. This authorization applies to all other insurances as applicable.

Section 2 — Assignment of Insurance Benefits

I hereby authorize direct payment of my surgical/medical benefits to Compassionate Kidney Care Inc. for services rendered by physician/healthcare provider employed by Compassionate Kidney Care Inc., in person or under his/her supervision. I understand that I am financially responsible for any balance not covered by my insurance.

Section 3 — Authorization to Release Information

I hereby authorize Compassionate Kidney Care Inc. to release any medical or incidental information necessary for either medical care or processing applications for financial benefit. Medicare/Medicaid: I certify that information given in applying for payment is correct. I authorize release of all records on request and request that payment of authorized benefits be made on my behalf.

Section 4 — Financial Agreement

I acknowledge that I am responsible for understanding their insurance requirements, including whether referrals, prior authorizations, or other approvals are required prior to specialty evaluation or treatment.

Compassionate Kidney Care Inc. may attempt to assist patients in obtaining required referrals or authorizations as a courtesy; however, ultimate responsibility for ensuring that valid referrals and authorizations are in place prior to the appointment remains with the patient.

Insurance verification performed by our office does not guarantee coverage or payment by your insurance carrier.

Certain services may not be covered by the patient's insurance plan and may be denied by the insurance company. In such cases, the patient acknowledges and accepts financial responsibility for any charges not covered by insurance.

Patients are responsible for all applicable out-of-pocket expenses like copayments, deductibles, coinsurance amounts, and non-covered services. Payment of patient responsibility amounts are be due at the time services are rendered.

Section 5 — Payment Options

We accept cash, VISA, MasterCard, and Discover. We do NOT accept checks or American Express. If you are experiencing financial hardship, please speak with our office staff to discuss available payment plan options.

I understand that the information that I have provided today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

I have the right to withdraw this consent at any time without affecting my right to future care.

Patient / Guardian Signature ✎	Printed Name	Date	☐ Patient ☐ Representative

Representative Full Name (if applicable)	Relationship to Patient

COMPASSIONATE KIDNEY CARE INC

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

This document provides the HIPAA Notice of Privacy Practices from Compassionate Kidney Care Inc., outlining how protected health information is handled, patient rights, and related policies.

Section 1 — Acknowledgement of Privacy Notice

I have received a copy of Compassionate Kidney Care's Notice of Privacy Practices (effective April 2026), which describes: how my protected health information (PHI) may be used and disclosed; my HIPAA rights; how the practice uses AI tools in my care; educational content offerings; and special protections for substance use disorder records.

✎ **I have received, read, and understand the Notice of Privacy Practices.** Initials: _____

Section 2 — AI Tools and Technology

Compassionate Kidney Care may use AI-assisted tools for clinical documentation, quality metrics, and administrative workflows. All AI tools comply with HIPAA and are covered by signed Business Associate Agreements. AI tools do not replace the physician — all clinical decisions are reviewed and approved by your provider.

✎ **I understand and consent to the use of HIPAA-compliant AI tools in my care.** Initials: _____

Section 3 — Substance Use Disorder Record Protections

Federal law (42 CFR Part 2) provides special protections for SUD records. SUD records cannot be disclosed without your specific written authorization and cannot be used against you in legal proceedings without your consent or a court order.

✎ **I understand that substance use disorder records have special protections under federal law.** Initials: _____

***SUD Records — Disclosure Preferences**

□ I AUTHORIZE disclosure of SUD-related records to treating physicians and specialists involved in my care.

□ I DO NOT authorize disclosure of SUD-related records (note: this may limit coordinated care).

For general records releases (NON-MEDICAL), ONLY check categories to EXCLUDE:

□ Drug / Alcohol use, treatment, or diagnosis	□ Mental illness or psychiatric treatment
□ Sexually transmitted disease information	□ HIV / AIDS diagnosis or treatment

Section 4 — *Contact Preferences

□ I authorize this practice to leave messages on my voicemail / answering machine.

□ Do NOT leave voicemail — call back only when I answer.

Alternative contact number (if different from primary)	Best time to call

Section 5 — Authorized Contacts

The following people are authorized to discuss my medical condition or billing information with this practice:

Authorized Contact 1 — Name	Relationship	Phone
Authorized Contact 2 — Name	**Relationship**	**Phone**

Section 6 — Educational Content — Optional Opt-In

Dr. Jones John, D.O. may operate or collaborate with an independent educational platform providing nephrology and kidney health education. Participation is entirely voluntary and is never a condition of care. Your PHI will not be shared with or sold to any external platform.

□ YES — I authorize Compassionate Kidney Care Inc. to use my contact information to send me occasional educational communications from or about platforms operated by Dr. Jones John, D.O. I may opt out at any time.

□ NO — I do not wish to receive educational communications.

Patient / Guardian Signature ✎	Printed Name	Date	□ Patient □ Representative

Representative Full Name (if applicable)	Relationship to Patient

COMPASSIONATE KIDNEY CARE INC

MALPRACTICE DISCLOSURE AND ARBITRATION AGREEMENT

PLEASE READ THIS IMPORTANT NOTICE ABOUT FLORIDA STATUTE §458.320, §458.327, §458.331 AND §625.52 — THESE ARE YOUR RIGHTS.

Malpractice Posting Disclosure

Under Florida law (Fla. Stat. §458.320, §458.327, §458.331), physicians are generally required to carry medical malpractice insurance or (Fla. Stat. §625.52) demonstrate financial responsibility to cover potential claims for medical malpractice. I HAVE DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE. This is permitted under Florida law under certain conditions. Florida law imposes penalties against non-insured physicians who fail to satisfy adverse judgements arising from claims of medical malpractice. This notice is provided pursuant of Florida law (Fla. Stat. § 458.320 & Fla. Stat. § 458.327, §458.331). Copies of applicable statutes are available upon request or posted in our office. This document MUST BE SIGNED before you initiate or continue medical care under Jones S. John, D.O. and Compassionate Kidney Care, Inc.

✎ **By entering my initials below I acknowledge that Dr. John has decided not to carry medical malpractice insurance and I agree to continue care under these terms.** Initials: _____

Article 1 — Agreement to Arbitrate

The patient and COMPASSIONATE KIDNEY CARE, INC., and JONES S. JOHN, D.O., hereinafter the undersigned Medical Care Provider ("MCP") - which includes any affiliated physicians, employees, any related medical group, professional association, or any other entity or individual which has provided medical services in conjunction with the MCP – agree to submit any dispute whatsoever to binding arbitration including without limitation any claim for malpractice, personal injury, battery, breach of express or implied contract, loss of consortium, wrongful death or any payment or any other disputes relating in any way to past, present or future medical care. Any dispute will go to binding arbitration. All Parties agree and understand that MCP does not have medical professional liability insurance and were informed prior to any care or services provided to the patient by the MCP.

Article 2 — All Claims Must Be Arbitrated

The patient, and/or his or her spouse, born or unborn children, parents, heirs, or anyone launching any legal or equitable action (hereinafter "the Patient") and the MCP agree that any complaint of any type which in any way relates to medical services shall, without exception, be submitted to binding arbitration. The governing law shall be the Federal Arbitration Act, state law notwithstanding. It is the express intention of the parties that any and all claims or complaints of any kind shall be submitted to and resolved by binding arbitration, which will be the exclusive and sole remedy. It is the specific and irrevocable intention of the parties to submit any question concerning this Agreement's arbitrability to the arbitrators only and to no other person or entity. For all issues regarding the validity of this Agreement in court, the prevailing party shall be entitled to attorney's fees and to costs as determined by the court. The MCP and any affiliated medical service provider that chooses to join in this Agreement agree to be equally bound just as the Patient is bound to binding arbitration in the event of any dispute. Such disputes can be brought by the MCP against the Patient, including terms of payment, services rendered, physical or emotional abuse, and other disputes. The Patient understands that any and all medical care provided is sufficient consideration, and the Patient will be fully and legally bound by this Agreement. Both parties to this Agreement are giving up their constitutional right to have any dispute decided in a court of law before a jury. All parties understand that they are giving up their right to have any dispute decided by a judge or jury through the court system. Resorting to the legal system by action at law or in equity will only be permissible if necessary, to enforce any decisions reached through arbitration. The parties agree that any dispute about any provisions of this Agreement will be decided through arbitration. The parties hereby bind anyone whose claims may arise out of or relate to treatment or services provided by the MCP at the time of the occurrence giving rise to the claim. In the case of any pregnant mother, the term "patient" means both the mother and the mother's expected child or children. The parties consent to the participation in this arbitration of any person or entity that would otherwise be a proper additional party in a court action if they have been involved in any way in the care of the Patient. This may include claims of the Patient against other physicians, nurses or medical professionals, or a hospital or other facility. Additionally, this Agreement is intended to resolve all claims for vicarious liability of the MCP .

Article 3 — Recovery

The signers agree that the maximum total amount of all noneconomic and economic damages combined shall never exceed $250,000.00, applied on a per case basis, regardless of the number of claimants seeking compensation, and regardless of the number of physicians, professional associations, employees or entities named as defendants. The Patient agrees to waive any and all rights to any higher award. This limitation applies regardless of whether another healthcare provider, such as a physician, a hospital or other facility or employees of such a physician, hospital or facility are named as defendants in the binding arbitration or in any other proceedings. "Noneconomic damages" means non-financial losses that would not have occurred but for the injury giving rise to the cause of action, including pain and suffering, inconvenience, physical impairment, mental anguish, disfigurement, loss of capacity for enjoyment of life, and other non-financial losses to the extent the claimant is entitled to recover such damages under general law, including the Wrongful Death Act. The arbitrators may choose to award damages in excess of $250,000.00 only when extreme hardship is demonstrated. As consideration for the limitation on any waivers, the MCP will pay up to and only the first $2,500.00 of attorney fees for the Patient. The parties agree that if any punitive damages are awarded, they may not exceed three times any compensatory award. Same as required by Medicare/Medicaid, the parties agree that any awards in excess of $10,000.00 shall be paid in equal annual payments over ten (10) years without being reduced to present value. The arbitrators may reduce the time period in cases of extreme hardship. They will also consider any other collateral sources of compensation (e.g., workers compensation, life insurance, disability, charitable, and governmental benefits, and other monies paid to the injured patient or any other party) which shall diminish any awards for noneconomic and/or economic damages. The MCP shall be entitled to an off-set for any monies received by the Patient for claims against any other health care provider, if such claims arise out of or relate in any way to the claims of the Patient against the MCP . The parties agree to the complete disclosure of all collateral sources of compensation. Failure to promptly disclose any additional sources on request is agreed to be grounds for immediate and total dismissal of any claim.

Article 4 — Statute of Limitations

In no case shall the statute of limitations exceed twelve (12) months from the date any alleged injury or problem could or should have been discovered regardless of the age of the Patient. The arbitrators and their empowerment under the FAA shall determine any question concerning the application of this provision. If this provision is held to be invalid it is replaced by the statute of limitations set forth in F.S. §766.

Article 5 — Severability

If any specific term or provision of this Agreement is determined by a court of competent jurisdiction to be illegal, invalid, or otherwise unenforceable, the entire remainder of this Agreement shall be construed to be in full force and effect, and all other provisions will still apply. The Parties agree in general that any provisions so challenged will be brought to the arbitrators to decide upon, and not to a judge or jury.

Article 6 — Merger Clause

This Agreement represents the entire agreement made between the MCP and the Patient. It supersedes any other agreements between the Patient and the MCP . Except as expressly set forth herein, there are no other representations, promises, understandings, or agreements of any kind between the parties. The Patient signing this Agreement acknowledges that he or she has not relied in any way upon any oral or written statements made to them besides what is contained within this Agreement. All parties acknowledge and understand that this Agreement cannot be changed, altered, or modified in any way except by an instrument in writing, signed by all parties.

Article 7 — Pronouns and Headings

The singular shall be held to include the plural, the plural held to include the singular, and the use of any gender shall be held to include every gender. All headings, titles, subtitles, or captions are inserted for convenience only, and are to be ignored in any construction of the provisions hereof.

Article 8 — Procedures and Applicable Law

The parties agree to try to resolve all issues within nine (9) months of any complaint. This Agreement, its substantive provisions, the scope of the Agreement, the authority granted to the arbitrators and the limitations contained in this Agreement, are to be governed by, and interpreted pursuant to the Federal Arbitration Act, any conflicting state law notwithstanding. To the extent not inconsistent with the FAA, it shall also be governed by the provisions of the Revised Uniform Arbitration Act as adopted in the principal state where the MCP practices. The parties agree that any dispute between them shall be determined by a panel of three arbitrators. Each party shall select one arbitrator from a list of qualified legal/medical experts provided by the MCP . All arbitrators will hold either Medical Degrees or both Medical and Juris Doctor Degrees. The two arbitrators selected shall then select a third arbitrator from the same list. Each party may remove the other's chosen arbitrator only once. The three arbitrators shall resolve any and all disputes between the parties pursuant to the National Arbitration Forum Code of Procedure or such procedures as they may jointly decide. All arbitration hearings shall be conducted by video conference; the MCP will provide equipment and pay all costs of video conference bridging and that of the arbitrators. The parties shall adopt rules of evidence such as the arbitrators may see fit. The MCP shall pay the full costs of the arbitration, but shall not be responsible for paying any fees or costs charged to the Patient by their attorney save the first $2,500.00 as indicated above. Reasonable discovery will be permitted by both sides. The parties agree that the arbitrators are to render a written decision with reasons stated for the decision. This agreement is to be construed to follow F.S. §766 and provides patient with all rights necessary under F.S. §766 and the Florida Medical Malpractice Act. With the exceptions of a right to a trial by jury and the statute of limitations, if there is a conflict between this Agreement and either F.S. §766 or the Florida Medical Malpractice Act then F.S. §766 or the Florida Medical Malpractice Act will prevail.

Article 9 — Right of Counsel and Rescission

The Patient understands that this Agreement is a legal document, and the Patient has the right to consult with an attorney before signing if desired. Your MCP encourages you to consult an attorney prior to signing or during a fifteen (15) day rescission period. You may rescind this Agreement for fifteen (15) days after signing it; you agree that it will be in full force and effect until the date received at the MCP's office. To rescind it, return a copy to the MCP by certified mail-return receipt only with "CANCELED" written on the first page, and signed by you underneath that word. The Agreement will then be rescinded for all future care, but you agree it will be valid for any and all care provided by the MCP to the Patient for the entire period of all medical services up to the rescission.

Article 10 — Authority to Sign

The Patient represents that he or she does have the authority to sign and execute this document on his/her own behalf (if signed by the Patient), or on behalf of the Patient (if signed by a person other than the Patient.)

Article 11 — No Undue Influence

The individual signing this Agreement hereby acknowledges that he or she has not been pressured, induced, coerced, or intimidated in any way into signing this agreement, and has signed it of his or her own free will and accord and not under duress of any kind. The parties agree that they have been given every opportunity to ask questions and received answers concerning the specifics and intent of their Agreement.

Article 12 — Frivolous Legal Actions

The Patient agrees that under no circumstances will a frivolous action or claim be brought against the MCP , and the MCP agrees to not bring any frivolous action or claim against the Patient. If two or more Arbitrators rule that any action or claim brought against either party if frivolous in nature, the prevailing party shall be entitled to economic and noneconomic damages, including loss of wages or other compensation, damage to reputation, full attorney's fees and punitive damages.

Article 13 — Mediation

At the MCP's sole expense, upon any complaint or alleged injury, the parties agree to promptly mediate in good faith with a qualified mediator prior to any arbitration hearing. A qualified professional mediator with medico-legal background shall be mutually agreed upon.

✎ **I hereby agree that all provisions of this Agreement are in full effect, and no word, sentence paragraph or provision may be crossed out, excised or removed. I hereby confirm I have read and understand this Arbitration Agreement and agree to resolve all disputes through binding arbitration.** Initials: _____

NOTICE: OUR GOAL IS TO PROVIDE YOU WITH THE BEST POSSIBLE CARE. AS PART OF THIS, WE ASK THAT ANY CONCERNS OR DISPUTES BE RESOLVED THROUGH BINDING ARBITRATION RATHER THAN THE COURT SYSTEM WITH ANY POTENTIAL DAMAGES LIMITED TO $250,000. BY SIGNING THIS CONTRACT, YOU AGREE TO HAVE ANY ISSUE OF ALLEGED MEDICAL NEGLIGENCE OR BREACH OF CONTRACT BETWEEN YOU AND YOUR MCP DECIDED BY BINDING ARBITRATION IN WHICH BOTH PARTIES GIVE UP THEIR RIGHT TO A TRIAL BY JURY OR BY A JUDGE.

Patient / Guardian Signature ✎	Printed Name	Date	□ Patient □ Representative

Representative Full Name (if applicable)	Relationship to Patient

COMPASSIONATE KIDNEY CARE INC

PATIENT AGREEMENT

Please review the full Compassionate Kidney Care Office Policy document at compassionatekidney.com under Office Policy By checking each item below you confirm you have read and understood that section.

Section 1 — Cancellation and No-Show Policy

☐ *I understand there will be a $25 cancellation fee if I give less than 48 hours notice or do not show for my appointment.

Section 2 — Auto-Dismissal After 3 No-Shows

☐ *I understand that 3 no-shows without 48-hour advance notice may result in dismissal from the practice.

Section 3 — Lab Results Review Policy

☐ *I understand that lab results are reviewed during a scheduled office visit. I am responsible for scheduling a follow-up to review results. I should not assume no news is good news.

Section 4 — Phone Communication Policy

☐ *I understand that calls without a voicemail may not receive a callback. I will leave a message to receive a call back.

Section 5 — Electronic Communications / Patient Portal

☐ *I understand that the Elation Health Patient Portal is the preferred method of communication. Portal messages are monitored during business hours — allow up to 2 business days for non-urgent responses.

Section 6 — Respectful Conduct

☐ *I agree to treat all staff, providers, and fellow patients with respect. Threatening or abusive behavior may result in dismissal from the practice.

Section 7 — Prescription Refill Policy

☐ *I understand that prescription refills may require an office visit to monitor for medication effects, side effects, and any necessary adjustments. I understand that refill requests require 72 hours via the patient portal.

Section 8 — After-Hours and Emergency Policy

☐ *I understand that Compassionate Kidney Care does not provide after-hours coverage. For emergencies I will call 911 or go to the nearest emergency room immediately.

Section 9 — Photography and Recording Policy

☐ *I understand that photography, audio, or video recording of staff, or the premises is prohibited without written consent.

Section 10 — Telemedicine

☐ *I understand and accept financial responsibility if my insurance does not cover the telemedicine visit. I understand the limitations of telemedicine and that I may be asked to schedule an in-person visit if deemed necessary by my provider.

Section 11 — AI limitations disclosure and audio video recording during visits.

☐ *I understand that HIPAA-compliant transcription, recording, and artificial intelligence (AI)-assisted technologies may be used to support clinical documentation, administrative workflows, and healthcare operations. I understand that AI tools do not replace physician judgment and that all clinical decisions remain the responsibility of my provider.

Section 12 — Educational Communication Authorization (Optional)

☐ *I voluntarily authorize Compassionate Kidney Care Inc. to send occasional educational and wellness-related communications associated with Dr. Jones John, D.O. through HIPAA-compliant communication channels, including the patient portal and email. I understand that participation is voluntary and may be revoked at any time without affecting my medical care.

Section 13 — Consent for treatment.

☐ *I consent to evaluation, diagnostic testing, medical treatment, and electronic prescribing as deemed medically appropriate by the providers and staff of Compassionate Kidney Care Inc. I authorize my provider to access and review my prescription medication history for treatment, medication management, and patient safety purposes as permitted by law..

By signing below I confirm I have read the full Compassionate Kidney Care Office Policy and agree to all terms above.

Patient / Guardian Signature	Printed Name	Date	☐ Patient ☐ Representative

Representative Full Name (if applicable)	Relationship to Patient

COMPASSIONATE KIDNEY CARE INC

MEDICAL HISTORY

SECTION 4 — REASON FOR VISIT

Check all that apply:

☐ Chronic Kidney Disease (CKD)	☐ Abnormal Kidney Function	☐ Protein in Urine (Proteinuria)
☐ Blood in Urine (Hematuria)	☐ Kidney Stones	☐ High Blood Pressure (Hypertension)
☐ Electrolyte Abnormality (Na, K, Mg)	☐ Dialysis Care / Evaluation	☐ Transplant Follow-up
☐ Hospital / Discharge Follow-up	☐ Second Opinion	☐ Other — describe below

Please briefly describe your reason for visit

SECTION 5 — ALLERGIES

☐ No Known Drug Allergies (NKDA)	☐ Known Allergies — list below:

Allergen / Medication / Food	Type	Reaction / What Happens?

SECTION 6 — PAST MEDICAL HISTORY

Check all existing conditions:

☐ High Blood Pressure	☐ Diabetes Mellitus	☐ Chronic Kidney Disease
☐ Heart Disease / CAD	☐ Heart Failure / CHF	☐ Atrial Fibrillation
☐ Stroke / TIA	☐ Peripheral Vascular Disease	☐ GI / Intestinal Disorder
☐ Neurologic Disorder	☐ Lung Disease / COPD	☐ Liver Disease / Hepatitis
☐ HIV / AIDS	☐ Lupus / Autoimmune Disease	☐ Cancer — Type: _____
☐ Thyroid Disease	☐ Sleep Apnea	☐ Gout
☐ Sickle Cell Disease	☐ Depression / Anxiety	☐ Other: _____

SECTION 7 — PAST SURGICAL HISTORY AND HOSPITALIZATIONS

Surgery / Procedure / Hospitalization	Date	Hospital / Facility	Notes / Complications

Hospitalizations in the past 6 months — details

Complications during past surgeries / hospitalizations (check all that apply):

☐ None	☐ Infection	☐ Bleeding
☐ Anesthesia Reaction	☐ Readmission	☐ Other

SECTION 8 — FAMILY HISTORY

Check conditions present in family members:

Condition	Father	Mother	Brother	Sister	Son	Daughter	Aunt/Uncle	Grandparent
Kidney Disease	☐	☐	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐	☐	☐
High Cholesterol	☐	☐	☐	☐	☐	☐	☐	☐
Lung Disease	☐	☐	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐	☐	☐
Autoimmune Disease	☐	☐	☐	☐	☐	☐	☐	☐
Other	☐	☐	☐	☐	☐	☐	☐	☐

Additional family history details

SECTION 9 — SOCIAL HISTORY

Occupation	Education Level

Habits

Smoking: ☐ Never ☐ Former ☐ Current

Cigarettes / day	Years smoked	Quit year (if former)

Alcohol: ☐ None ☐ Occasional ☐ Moderate ☐ Heavy

Drinks / week	Type (beer / wine / spirits)	

Recreational Drug Use: ☐ No ☐ Occasionally ☐ Regularly

Substance use history is protected under HIPAA and 42 CFR Part 2 and used solely for your safe, complete care.

Substance(s) and frequency (if applicable)

SECTION 10 — CURRENT MEDICATIONS, VITAMINS AND SUPPLEMENTS

List ALL medications, vitamins, supplements, and herbal products currently taken — including over-the-counter. Bring medication bottles or attach a printed list if preferred.

☐ No current medications	☐ Attached separate medication list	☐ Brought medication bottles

COMPASSIONATE KIDNEY CARE INC

Medication / Vitamin / Supplement Name	Dose	How Often	Route	Prescribing Provider

COMPASSIONATE KIDNEY CARE INC

SECTION 11 — REVIEW OF SYSTEMS

Check any symptoms you are currently experiencing or have had recently. Leave blank if none.

General

- ☐ Fever
- ☐ Chills
- ☐ Unintentional weight loss
- ☐ Unintentional weight gain
- ☐ Fatigue / low energy
- ☐ Night sweats

Eyes

- ☐ Vision changes
- ☐ Blurry vision
- ☐ Double vision
- ☐ Red or dry eyes

Head / Ears / Nose / Throat

- ☐ Bloody nasal discharge
- ☐ Sore throat
- ☐ Ear pain
- ☐ Sinus infection

Respiratory

- ☐ Cough
- ☐ Wheezing
- ☐ Shortness of breath at rest
- ☐ SOB on minimal exertion

Cardiac

- ☐ Chest pain
- ☐ Palpitations / racing heart
- ☐ Irregular heartbeat
- ☐ Leg swelling
- ☐ Difficulty laying flat

Gastrointestinal

- ☐ Nausea
- ☐ Vomiting
- ☐ Abdominal pain
- ☐ Diarrhea
- ☐ Constipation
- ☐ Blood or black stools
- ☐ Metallic taste
- ☐ Poor appetite

Genitourinary

- ☐ Foamy / frothy urine
- ☐ Urinary urgency
- ☐ Difficulty urinating
- ☐ Blood in urine
- ☐ Cola-colored urine
- ☐ Urinating at night
- ☐ Urinary incontinence

Musculoskeletal

- ☐ Joint pain
- ☐ Muscle weakness
- ☐ Muscle aches
- ☐ Joint swelling
- ☐ Limited range of motion

Skin

- ☐ Rash
- ☐ Easy bleeding
- ☐ Easy bruising
- ☐ Generalized itching

Endocrine

- ☐ Excessive thirst
- ☐ Heat or cold intolerance
- ☐ Lightheadedness on standing

FOR OFFICE USE ONLY

Date received	Staff initials	PDF generated	Uploaded to Elation	Chart updated
		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No