Welcome to Altitude Kidney Health, a new and higher quality patient experience for patients with kidney disease!

We look forward to working with you. To help us serve you better, please make note of the following details pertinent to your visit:

- *Please fill out the attached new patient registration forms* to the best of your ability, then submit:
  - By fax: (855-515-2497), or
  - Print and bring them to your appointment
- *Please prepare for your appointment*, including:
  - Be ready to submit a urine sample for your provider's review in clinic
  - Bring your list of medications, vitamins, supplements, herbs, etc. including their bottles
  - Bring a list of your other providers so we can better communicate with your whole care team
- *You can see the provider by telehealth!* (ie, remotely via video) If you would like to do so, please ask for assistance with the easy setup.
- *Should you need to cancel*, kindly notify us 48 hours in advance. For cancellations made within 24 hours, we will attempt to fill your spot, but if we are unable, you may be subject to a cancellation fee.

Warmly,

Your Altitude Kidney Health team
720-500-3439

NEW PATIENT REGISTRATION

Name:			Contact info:	
Nickname/preferred:			Email:	
Date of birth:			Home phone:	
Social Security Number:			Cell phone:	
Gender *(select one)* :	□ M □ F □ nonbinary		Emergency contact: *(phone #)*	
Residence address *(street)* :			How may we contact you? *(check)* :	□ home phone □ cell phone □ email □ next of kin □ voicemail OK
City, State, Zip code:			Race *(check)* : *Prefer no answer* □	□ American Indian/Eskimo □ Black/African American □ Hawaiian/Pacific Islander □ Asian □ White
Mailing street address *(if different)* :			Ethnicity *(check)* : *Prefer no answer* □	□ Hispanic/Latino □ Not Hispanic/Latino
City, State, Zip code:			Do you have a living will/advanced directive?	
Primary care provider: *(location/contact info)*			Primary insurance:	
Referring provider:			Group #:	
Other doctors/providers: *(location/contact as able)*			ID #:	
			Secondary insurance:	
Local pharmacy & cross streets:			Group #:	
Mail order pharmacy			ID #:	

Initials: _____

Please check or mark "x" if yes (blank if no), and kindly fill in known details where appropriate:

Medical history	**Yes?**	**Kidney problems**	**Yes?**	**Pregnancy**	**Yes?**
High blood pressure:	☐	Kidney stone	☐	Total #: _____	-
Diabetes mellitus:	☐	Kidney cancer	☐	Living children, #: _____	-
Coronary artery disease:	☐	Kidney cyst	☐	Hypertension while pregnant:	☐
Heart attack:	☐	Kidney absent/loss	☐	Protein in urine while pregnant:	☐
Heart failure:	☐	Prostate enlargement:	☐	Miscarriages:	☐
Irregular heart beat/Afib:	☐	UTIs *(urinary tract infection)* :	☐	Elective abortions:	☐
Pulmonary hypertension:	☐	Kidney inflammation:	☐	History of vaginal birth:	☐
Blood clot in leg:	☐	Kidney infection	☐	Last menstrual cycle: _____	-
Blood clot in lung:	☐	Other:	☐	In menopause:	☐
Bleeding problems:	☐				
Taking blood thinners?:	☐			**Social history**	**Yes?**
Stroke:	☐	**Surgical History**	**Year**	Sexually active:	☐
High cholesterol:	☐	Heart catheterization:		Smoked tobacco *(years?)* : _____	☐
Edema (swelling):	☐	Heart bypass *("CABG")* :		Chew tobacco *(years?)* : _____	☐
Liver cirrhosis:	☐	Heart valve surgery:		Alcohol *(drinks/week?)* : _____	☐
Gallstones:	☐	Neck artery surgery:		Injection drugs *(which?)* : _____	☐
Other liver disease:	☐	Bladder surgery:		Other drugs *(which?)* : _____	☐
Reflux:	☐	Prostate surgery:		Exercise *(days/week:* _____):	☐
Stomach ulcer:	☐	Hysterectomy:		○ Single ○ Partnered ○ Married	
Pancreas disease:	☐	Back surgery:		Live with: _____	
Chronic foot infections:	☐	Joint surgery *(other)* :		Occupation: _____	
Chronic blood infections:	☐	Appendectomy:			
Pneumonia:	☐	Gallbladder removal:		**(Yes?) Family medical history**	**Who?** *(if yes)*
Tuberculosis:	☐	Gastrict bypass:		☐ Kidney disease	
HIV:	☐	Other:		☐ Diabetes	
Hepatitis? *(check)* : ☐ B? ☐ C?				☐ Hypertension	
Chronic pain:	☐	**Allergies/allergens**	**Reaction?**	☐ Heart disease	
Pain, other:	☐			☐ Stroke	
Cancer *(type)* : _____	☐			☐ Cancer	
Cancer *(type)* : _____	☐			☐ Other: _____	
Other:	☐			☐ Other: _____	

Hospitalizations: Initials: _____