ASSOCIATED RENAL & HYPERTENSION GROUP, PC

7 Cedar Grove Ln., Suite 31, Somerset, NJ 08876
Tel: (732) 873-1400 Fax: (732) 960-3444 www.associatedrenal.com

Patient Name: _____ Social Security Number: _____

Date of Birth: _____ SEX: M __ F __ Marital Status: S __ M __ D __ W __

Street Address: _____ Apt. No.: _____

City: _____ State _____ Zip Code: _____

Home phone: (_____) _____ Work phone: (_____) _____

Cell/Pager number: (_____) _____ Email Address: _____

Guardian/Parent if patient is a minor: _____

Emergency Contact Name: _____ Emergency Contact Phone: (_____) _____

Guarantor's Name: _____

Guarantor's Social Security Number: _____ - _____ - _____ Guarantor's Date of Birth: _____

Relationship to Patient: _____

Guarantor's Address: _____ Apt. No.: _____

City: _____ State _____ Zip Code: _____

Home phone: (_____) _____ Cell/Pager number: (_____) _____

Employer's Name: _____ Work Phone: (_____) _____

Employer's Address: _____

Insurance Information

Primary Insurance Company's Name: _____
Insurance Address: _____ City: _____
State _____ Zip Code: _____ Phone Number (____) _____
Name of Policy Holder: _____ Date of Birth: _____
Insurance ID Number: _____ Group Number: _____

Secondary Insurance Company's Name: _____
Insurance Address: _____ City: _____
State _____ Zip Code: _____ Phone number (____) _____
Name of Policy Holder: _____ Date of Birth: _____
Insurance ID Number: _____ Group Number: _____

Referral Information

Referring Physician _____ Specialty: _____

City _____ State _____ Zip _____

Associated Renal & Hypertension Group, PC

Parisa Hakimzadeh, DO | M. Betsy Srichai, MD
Primabel Gina Obias, MD | Kobena Dadzie, MD
7 Cedar Grove Ln., Suite 31, Somerset, NJ 08873 Tel: 732-873-1400 Fax:732-960-3444

AUTHORIZATON FOR THE RELEASE OF MEDICAL RECORDS

I hereby authorize _____to release my medical records.

Patient's Name _____

Patient's Address _____

_____

Patient's Date of Birth _____ **Social Security Number** _____

Please forward the following records:

____All Records

____H&P

____Progress Notes

____Consultants' Letters

____Medication List

____All Lab Results

____Lab Results from:

___/___/_____ till ___/___/_____.

____Radiology Reports

____EKG/ECHO Results

____Other: _____

SEND TO:

Associated Renal & Hypertension Group

Parisa Hakimzadeh, DO | M. Betsy Srichai, MD
Primabel Gina Obias, MD | Kobena Dadzie, MD
7 Cedar Grove Ln., Suite 31
Somerset, NJ 08873
Phone: 732-873-1400 Fax: 732-960-3444

Patient's Signature:_____**Date:**_____

Associated Renal and Hypertension Group, PC

Patient's Name: _____ DOB: _____

Local Pharmacy: _____ Phone # _____

Mail Order Pharmacy: _____

****

When we call our patients with results or appointment information:

It is ok to leave a message on my answering machine Yes _____ No _____

I authorize you to speak to those listed below regarding my medical information:

Name: _____ Relationship to Patient _____

Name: _____ Relationship to Patient _____

Patient Signature: _____

****

Primary Care Physician: _____

Other doctors involved in my care:

_____

_____

_____

_____

_____

_____

_____

PATIENT NAME: _____ DOB: _____

GENERAL:

YES / NO WEIGHT LOSS / GAIN
YES / NO FATIGUE / DEPRESSED
YES / NO DIFFICULTY SLEEPING
YES / NO FEVER / SWEATS / CHILLS
YES / NO PAIN
YES / NO FEELING WELL IN GENERAL

VISION:

YES / NO CHANGE IN VISION
YES / NO DOUBLE / BLURRY EYES
YES / NO CHANGE IN COLOR
YES / NO JAUNDICE (YELLOWING OF THE EYES)
YES / NO EYE DISORDERS

HEAD/NECK:

YES / NO PAIN
YES / NO SORES IN/AROUND MOUTH
YES / NO LUMPS / BUMPS
YES / NO CHANGE IN HEARING
YES / NO HEADACHES

PULMONARY:

YES / NO SHORTNESS OF BREATH DURING ACTIVITIES
YES / NO COUGH
YES / NO COUGHING UP BLOOD
YES / NO WHEEZING
YES / NO SNORING DURING SLEEP
YES / NO PULMONARY DISORDERS

CARDIOVASCULAR:

YES / NO SHORTNESS OF BREATH WHILE LYING DOWN
YES / NO CHEST PAIN / PRESSURE DURING ACTIVITES
YES / NO EDEMA (SWELLING IN LEGS)
YES / NO RAPID / IRREGULAR HEART BEAT
YES / NO LEG PAIN / CRAMPS
YES / NO WOUNDS IN FEET
YES / NO CARDIOVASCULAR DISORDERS

GASTROINTESTINAL:

YES / NO HEARTBURN
YES / NO ABDOMINAL PAIN
YES / NO DIFFICULTY SWALLOWING
YES / NO NAUSEA OR VOMITING
YES / NO VOMITING BLOOD
YES / NO BLACK / BLOODY STOOLS
YES / NO CONSTIPATION
YES / NO DIARRHEA
YES / NO GI DISORDERS

URINARY/GENITO:

YES / NO BLOOD IN URINE
YES / NO BURNING WHILE URINATING
YES / NO URINATION AT NIGHT
YES / NO FREQUENT URINATING
YES / NO FREQUENT URINARY TRACT INFECTIONS
YES / NO URINARY DISORDERS / STONES

HEMATOLOGY/ONCOLOGY:

YES / NO ABNORMAL BLEEDING / BRUISING
YES / NO NEW GROWING LUMPS / BUMPS
YES / NO BLOOD CLOTTING DISEASES

NEUROLOGICAL:

YES / NO SEIZURES
YES / NO NUMBNESS / WEAKNESS
YES / NO BALANCE PROBLEMS / DIZZINESS
YES / NO HEADACHES / TREMORS
YES / NO HAVE YOU EVER FAINTED
YES / NO LOSS OF CONSCIOUSNESS
YES / NO SUDDEN LOSS OF FUNCTION
YES / NO NEUROLOGICAL DISORDERS

ENDOCRINE:

YES / NO POLYDIPSIA (VERY THIRSTY)
YES / NO POLYURIA (URINATING LARGE AMOUNTS)
YES / NO POLYPHAGIA (INCREASE IN EATING)
YES / NO FATIGUE
YES / NO DISORDERS

MUSCULOSKELETAL:

YES / NO JOINT PAIN
YES / NO MUSCLE PAIN / ACHES
YES / NO JOINT SWELLING / REDNESS
YES / NO ARTHRITIS
YES / NO MUSCULOSKELETAL DISEASES

MENTAL HEALTH:

YES / NO SADNESS / DEPRESSION / ANXIETY
YES / NO ALCOHOL OR SUBSTANCE ABUSE
YES / NO MEMORY PROBLEMS
YES / NO CONFUSION
YES / NO ANY DISORDERS

INFECTIOUS DISEASES:

YES / NO ANY DISEASES

SKIN/HAIR:

YES / NO HAIR LOSS
YES / NO ITCHY SKIN / RASHES
YES / NO SORES THAT DON'T HEAL
YES / NO LESIONS
YES / NO ANY DISORDERS

WOMEN ONLY (OB/GYN):

YES / NO VAGINAL DISCHARGE
YES / NO BREAST PAIN / LUMPS
YES / NO BIRTH CONTROL
YES / NO MENSTRUAL CYCLE NORMAL
YES / NO PREGNANCIES
YES / NO CHRONIC OR PAST DISEASES

ANY PAST SURGERIES:

BRIEFLY DESCRIBE ANYTHING ELSE WE SHOULD KNOW:

MEDICAL HISTORY RECORD

Reason for Visit Today: _____

Medical History (Patient)		**Family History**	**IF LIVING** Age / Health Conditions	**IF DECEASED** Deceased Age / Death Cause
Anemia	Yes___No___	Father		
Stroke	Yes___No___	Mother		
Diabetes (Type 1 or 2)	Yes___No___			
High Blood Pressure	Yes___No___	Siblings (circle sex)		
Blood Clots	Yes___No___	1. M F		
Heart Disease	Yes___No___	2. M F		
Coronary Disease	Yes___No___	3. M F		
Heart Attacks	Yes___No___	4. M F		
Congestive Heart Failure	Yes___No___	5. M F		
Atrial Fibrillation	Yes___No___			
High Cholesterol	Yes___No___	Children (circle sex)		
Hepatitis (A,B,C)	Yes___No___	1. M F		
Thyroid	Yes___No___	2. M F		
Cancer (type)	Yes___No___	3. M F		
Urinary Tract Infections	Yes___No___	4. M F		
Incontinence	Yes___No___	5. M F		
Kidney Stones	Yes___No___			
Gout	Yes___No___			

Other_____

List of Current Medications

Name	Dosage	Frequency

Allergies

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IMPORTANT OFFICE POLICIES

RELEASE OF MEDICAL INFORMATION

I authorize *Associated Renal & Hypertension Group, P.C.* to release the medical records concerning the above patient to any physician, hospital, or agency involved in the care of this patient.

PAYMENT POLICY

Co-payments are to be collected at the time services are received. We accept cash, or checks.
All medical services provided are directly charged to the patient or responsible party. You will be responsible for any balance deemed: patient responsibility/non-payable/non-covered by your insurance and billed accordingly.
Payment is expected in full upon receipt of statement or payment arrangements must be made with our billing office.

CANCELLATION POLICY

Our office requests that if an appointment needs to be cancelled that we receive notice no later than24 hours prior to the appointment. We reserve the right to charge $50.00 for a "no show" appointment, to be collected on or before your next appointment.

REFERRAL POLICY

I understand that it is my responsibility to obtain a referral through my primary care physician's office if required by my insurance company. Failure to do so will result in charges being billed directly to myself.

I HAVE READ, UNDERSTAND, AND AGREE TO ABIDE BY THE ABOVE RELEASE OF MEDICAL INFORMATION, PAYMENT, AND OTHER OFFICE POLICIES.

Signature of Responsible Party: _____ Date: _____

ASSIGNMENT OF MEDICAL BENEFITS

I authorize my insurance carrier to assign all medical benefits, if applicable, to *Associated Renal & Hypertension Group, P.C.* I also authorize release of medical information necessary to process all medical insurance claims. I hereby authorize my insurance benefits to be paid directly to *Associated Renal & Hypertension Group, PC.* I understand and am responsible for all Charges. including my added costs incurred due any effort to collect for services rendered. I realize I am responsible to pay for non-covered services and I hereby authorize the release of pertinent medical information to insurance carriers.

Signature of Responsible Party: _____ Date: _____

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ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

By signing this form, you acknowledge that Associated Renal & Hypertension Group, PC has given you a copy of its Notice of Privacy Practices. This notice explains how your health information will be handled. HIPAA, the federal law concerning medical privacy, requires this notice.

I have received a copy of the Notice of Privacy Practices. The Associated Renal & Hypertension Group, PC has given me the opportunity to ask any questions about this notice, and all my questions have been answered.

_____

Patient's Name Printed

_____

Patient or Guardian's Signature

_____

Date Signed

Provider Use Only

If the patient was not able to sign due to an emergency, or did not want to sign, please document if the patient was given the notice and the reason why the patient did not sign.

Patient was given this notice: _____Yes _____No

Reason signature was not obtained:

_____

Staff Signature Date

ASSOCIATED RENAL & HYPERTENSION GROUP
7 CEDAR GROVE LANE, SUITE 31
SOMERSET, NJ 08873
732-873-1400

DIRECTIONS TO OUR OFFICE

FROM NEWARK AIRPORT

New Jersey Turnpike South to Exit 9 NEW BRUNSWICK
Bear right after toll booth
Get into the two LEFT lanes
Follow signs for ROUTE 18 NORTH / NEW BRUNSWICK
Follow directions below from **ROUTE 18**

FROM ROUTE 18

Route 18 NORTH through New Brunswick
Take exit for EASTON AVE/S. BOUND BROOK
Follow road to traffic light, make LEFT onto LANDING LANE
At next light, make RIGHT onto EASTON AVE, travel approx. 3.1 miles
Stay in LEFT lane, at traffic light for CEDAR GROVE LANE, make LEFT
Make RIGHT turn into Mandell's Plaza

FROM ROUTE 287

Route 287 to Exit 10 NEW BRUNSWICK/EASTON AVE
At first traffic light, make RIGHT onto CEDAR GROVE LANE
Make RIGHT turn into Mandell's Plaza

FROM PRINCETON

Route 27 NORTH, make LEFT onto SOUTH MIDDLEBUSH ROAD (Route 615)
Turn LEFT on Amwell Road
Turn RIGHT onto CEDAR GROVE LANE
Approx 3 miles, office will be on LEFT (Mandell's Plaza)

Any Questions, Please Call Our Office
732-873-1400