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: _____

****

I authorize ARHG to forward my medical records to the following physicians:

Primary Care Physician: _____

Other doctors involved in my care:

_____

_____

_____

_____

_____

_____

_____

NAME:_____ DOB_____

GENERAL:
YES / NO WEIGHT LOSS/GAIN
YES / NO FEVER / SWEATS / CHILLS
YES / NO FATIGUE / DEPRESSION
YES / NO EXCESSIVE SWEATING
YES / NO APPETITE CHANGE
YES / NO ACTIVITY CHANGE
YES / NO PAIN

EYES:
YES / NO EYE DISCHARGE
YES / NO EYE ITCHING
YES / NO EYE PAIN
YES / NO EYE REDNESS
YES / NO SENSITIVITY TO LIGHT
YES/ NO CHANGE IN VISION
YES / NO DOUBLE / BLURRY EYES

HEAD/NECK:
YES / NO CONGESTION
YES / NO DENTAL PROBLEM
YES / NO DROOLING
YES / NO EAR DISCHARGE
YES / NO EAR PAIN
YES / NO FACIAL SWELLING
YES / NO HEARING LOSS / CHANGE IN HEARING
YES / NO MOUTH SORES
YES / NO NOSEBLEEDS
YES / NO POSTNASAL DRIP
YES / NO SINUS PAIN / PRESSURE
YES / NO SORE THROAT
YES / NO TINNITUS
YES / NO TROUBLE SWALLOWING
YES / NO VOICE CHANGE

RESPIRATORY:
YES / NO SLEEP APNEA
YES / NO SNORING
YES / NO CHEST TIGHTNESS
YES / NO CHOKING
YES / NO SHORTNESS OF BREATH
YES / NO WHEEZING
YES / NO COUGH
YES / NO COUGHING UP BLOOD

CARDIOVASCULAR:
YES / NO CHEST PAIN
YES / NO LEG SWELLING
YES / NO PALPITATIONS
YES / NO IRREGULAR HEARTBEAT
YES / NO SHORTNESS OF BREATH WHEN LYING DOWN

MENTAL HEALTH:
YES / NO AGITATION
YES / NO BEHAVIOR PROBLEMS
YES / NO CONFUSION
YES / NO DECREASED CONCENTRATION
YES / NO HALLUCINATIONS
YES / NO HYPERACTIVE
YES / NO NERVOUS/ ANXIOUS
YES / NO SELF INJURY
YES / NO SLEEP DISTURBANCE
YES / NO SUICIDAL IDEAS
YES / NO ALCOHOL OR SUBSTANCE ABUSE

GASTROINTESTINAL:
YES / NO ABOMINAL DISTENTION
YES / NO ABOMINAL PAIN
YES / NO ANAL BLEEDING
YES / NO BLACK / BLOODY STOOL
YES / NO CONSTIPATION
YES / NO DIARRHEA
YES / NO NAUSEA OR VOMITING
YES / NO RECTAL PAIN
YES / NO HEARTBURN
YES / NO DIFFICULTY SWALLOWING
YES / NO VOMITING BLOOD

ENDOCRINE:
YES / NO COLD OR HEAT INTOLERANCE (CIRCLE ONE)
YES / NO EXCESSIVE THIRST
YES / NO EXCESSIVE HUNGER
YES / NO EXCESSIVE URINATION

URINAY/GENITO:
YES / NO DIFFICULTY URINATING
YES / NO PAINFUL INTERCOURSE
YES / NO PAINFUL URINATION
YES / NO URINATION AT NIGHT
YES / NO FLANK PAIN
YES / NO URINARY FREQUENCY
YES / NO BLOOD IN URINE
YES / NO PELVIC PAIN
YES / NO URGENCY
YES / NO URINE DECREASED
YES / NO KIDNEY STONES

NEUROLOGICAL:
YES / NO DIZZINESS
YES / NO FACIAL ASYMMETRY
YES / NO HEADACHES / TREMORS
YES / NO LIGHT HEADEDNESS
YES / NO NUMBNESS / WEAKNESS
YES / NO SEIZURES
YES / NO SPEECH DIFFICULTY
YES / NO FAINTING

MUSCULOSKELETAL:
YES / NO MUSCLE PAIN
YES / NO BACK PAIN
YES / NO JOINT SWELLING
YES / NO NECK PAIN / STIFFNESS
YES / NO ARTHRITIS

SKIN/HAIR:
YES / NO HAIR LOSS
YES / NO ITCHY SKIN / RASHES
YES / NO LESIONS
YES / NO COLOR CHANGE

HEMATOLOGIC:
YES / NO BRUISES EASILY

OB/GYN (WOMEN ONLY):
YES / NO VAGINAL DISCHARGE
YES / NO BREAST PAIN / LUMPS
YES / NO BIRTH CONTROL
YES / NO MENTRUAL CYCLE NORMAL
YES / NO PREGNANCIES
YES / NO PREECLAMPSIA

ANY PAST SURGERGIES:

_____
_____
_____
_____

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