



Renal Physicians of Montgomery County, P.A.

Diplomate in American Board of Internal Medicine Nephrology

200 River Pointe Dr. Ste. 120 17191 St. Luke's Way Ste. 260 116 Medical Park Ln. 425 Holderrieth Blvd. Ste.105
Conroe, TX 77304 The Woodlands, TX 77385 Huntsville, TX 77340 Tomball, TX 77375

Phone: 936-756-2555 Fax: 936-756-2534

RPMCKidneydoc.com

We are happy that Dr. _____ referred you to our practice and we look forward to seeing you on _____ at _____. To Help insure the best possible result during your visit, please be aware that your previous medical records from the last 6 months are necessary. If we do not have these records, we will be unable to see you. Please contact your referring doctor's office and obtain copies of your records to bring with you or ask them to fax them immediately to our office at 936-756-2534.

Please bring the following items with you to your appointment

- Insurance and/or Medicare ID cards and a photo ID
- A referral from your primary physician if your insurance requires it
- All new patient paperwork filled out
- Arrive 10 minutes early to process new patient paperwork

Note: If you have NO insurance coverage, payment is due at time of services rendered. If unable to pay at that time, please inform our office staff to make payment arrangements.

MEDICATION REFILL POLICY

We ask our patients to allow 48 hours for medication refills. Please phone your pharmacy first, then they will contact our office for the approval of the refill.

Thank you

Thank you for selecting our healthcare team! We will strive to provide you with the best possible healthcare. To help us meet all your healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us - we will be happy to help.

Personal Information

Date _____
Birthdate _____
SS #/SIN _____
Name _____
Wishes to be called _____
 Male Female Minor Single Married Divorced Widowed Separated
Address _____
City _____ State/Prov. _____ Zip/P.C. _____
Employer _____ Occupation _____
Referred by _____

Contact Information

Home Phone _____ Pharmacy Phone # _____
Work Phone _____ Ext. # _____
Cell Phone _____ E-Mail: _____
Where do you prefer to receive calls? Home Work Cell Phone
When is the best time to reach you? Time _____ Days _____
In the event of an emergency, who should we contact?
Name _____ Relationship _____ Work # _____ Home # _____

Insurance Information

Primary Insurance

Additional Insurance

Name of Insured _____	Name of Insured _____
Relationship to patient _____	Relationship to patient _____
Insured's birthdate _____	Insured's birthdate _____
SS #/SIN _____	SS #/SIN _____
Employer _____	Employer _____
Date Employed _____	Date Employed _____
Occupation _____	Occupation _____
Insurance Company _____	Insurance Company _____
Group # _____	Group # _____
Employee/Cert. # _____	Employee/Cert. # _____
Ins. Co. Address _____	Ins. Co. Address _____
Deductible _____	Deductible _____
Amount already used _____	Amount already used _____
Max. annual benefit _____	Max. annual benefit _____

Welcome to Renal Physicians. Please fill out the information found below to the best of your ability.

Patient name _____ Date of Birth _____ SS# _____

Chief Complaint(reason you are coming to see us) _____

Present illness: Location of problem _____ Signs/Symptoms _____

Past Medical History: Have you ever had any of the following?

Condition....	No	Yes	Parent	Sibling	Condition....	No	Yes	Parent	Sibling
AIDS or HIV+					Measles				
Anemia					Migraine/Headaches				
Any other disease					Mitral Valve Prolapse				
Arthritis					Mumps				
Asthma					Pneumonia				
Back trouble					Polio				
Bladder infections					Rheumatic fever				
Bleeding tendency					Scarlet fever				
Blood Transfusion					Smallpox				
Bronchitis					Stroke				
Cancer					Thyroid disease				
Chickenpox					Tuberculosis				
Diabetes					Ulcer				
Diphtheria					Venereal Disease				
Epilepsy					Whooping cough				
Glaucoma									
Heart Disease					Date of last Chest XRay				
Hemorrhoids					Other				
Hepatitis					Other				
Hernia					Other				
High blood pressure					Other				
Hives or Eczema					Other				
Infectious Mono					Other				
Kidney disease					Other				
Low blood pressure					Other				

Allergic/Immunologic: (history of skin reaction or other adverse reaction)

Condition	Yes	No
Penicillin or other antibiotics		
Morphine, Demerol or other Narcotics		
Novocain or other Anesthetics		
Aspirin or other Pain Remedies		
Tetanus or other Serums		
Iodine, Merthiolate or other Antiseptic		
Other drugs/medications		

Previous Hospitalizations/Surgeries/Serious Illnesses: When? Hospital, City & State

HEALTH HISTORY



Renal Physicians of Montgomery County, P.A.

200 River Pointe Dr. Ste. 120 17191 St. Luke's Way Ste. 260 116 Medical Park Ln. 425 Holderrieth Blvd. Ste.105

Conroe, TX 77304

The Woodlands, TX 77385

Huntsville, TX 77340

Tomball, TX 77375

Phone: 936-756-2555

Fax: 936-756-2534

Patient Name: _____ DOB: _____ SSN# _____

Telephone: home _____ Cell _____ Work _____

I authorize Renal Physicians of Montgomery County, P.A. to furnish information to insurance carriers concerning my illness and treatments of necessary to process my insurance claim(s). I hereby assign to Renal Physicians of Montgomery County, P.A. all payments for medical service rendered to myself. I understand that I am responsible for any amount not covered by any insurance including all office visits, procedures and injections.

(Signature of Patient)

(Date)

There are times when a close friend, caregiver or relative calls our office to ask questions concerning your medical condition, treatment or account balance. We need your authorization to release this information. Without this information, we will not be able to give out your personal information.

(Name)

(Relationship)

(Phone Number(s))

(Name)

(Relationship)

(Phone Number(s))

(Name)

(Relationship)

(Phone Number(s))

I give my permission for information to be given to the people listed above. This information can include, but is not limited to, any and all medical information. Including office or hospital visits, billing and account information, appointments and medical records. I understand this information will or could be released to any of my other physicians or any physicians I may be referred to.

Medical Records Release: I give my permission to Renal Physicians of Montgomery County, P.A. to request and release any of my medical records to any physician that requires them for treatment of my medical care.

(Signature of Patient)

(Date)



Renal Physicians of Montgomery County, P.A.

200 River Pointe Dr. Ste. 120 17191 St. Luke's Way Ste. 260 116 Medical Park Ln. 425 Holderrieth Blvd. Ste.105
Conroe, TX 77304 The Woodlands, TX 77385 Huntsville, TX 77340 Tomball, TX 77375
Phone: 936-756-2555 Fax: 936-756-2534

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Name _____ Date of Birth _____ SS# _____

Address _____ Telephone _____

I, Hereby Request and Authorize

Physician or institution _____

Telephone _____ Fax _____

Address _____

TO RELEASE INFORMATION FROM THE MEDICAL RECORDS TO:

RENAL PHYSICIANS FO MONTGOMERY COUNTY, P.A. FAX: 936-756-2534

Dr. Darshan Tolat Dr. Syed Zaidi Dr. Roohi Khan

Treatment Dates _____ of Medical Care.

PLEASE SEND: PHYSICIAN DICTATED OR HANDWRITTEN CONSULT OR FOLLOW-UP NOTES, DISCHARGE SUMMERY, OP REPORTS, ALL LABWORK, MRI/MRA REPORTS, U/S REPORTS, CT, EKG, CXR, ALL RADIOLOGY, URINE TEST....

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results, or AIDS information.

I, the undersigned, have read the above and authorize the staff listed above to disclose such information as herein contained. I understand that this consent may be withdrawn by me at any time except to the extent that action has been taken in reliance upon it. I understand that when this information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected. This facility is released and discharged of all legal responsibility and liability resulting from the release of this information and I, the undersigned, waive, on behalf of myself, my heirs, assigns and any person who may have an interest in the matter, all provisions of law relating to the disclosure of this Protected Health Information.

Date: _____ Signature: _____

Relationship to Patient: _____



Renal Physicians of Montgomery County, P.A.

Diplomate in American Board of Internal Medicine Nephrology

200 River Pointe Dr. Ste. 120 17191 St. Luke's Way Ste. 260 116 Medical Park Ln. 425 Holderrieth Blvd. Ste.105

Conroe, TX 77304

The Woodlands, TX 77385

Huntsville, TX 77340

Tomball, TX 77375

Phone: 936-756-2555

Fax: 936-756-2534

RPMCKidneydoc.com

**Acknowledgement of Review of
Notice of Privacy Practices**

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

(Signature of Patient)

(Date)

(Personal Representative)

(Date)