



# RENAL PHYSICIANS OF MONTGOMERY COUNTY, P.A.

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 \_\_\_\_\_ Email \_\_\_\_\_  
SS # / SIN \_\_\_\_\_  
Do you have an advanced directive? \_\_\_\_\_  
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

Name of Insured \_\_\_\_\_  
Relationship to patient \_\_\_\_\_  
Insured's birthdate \_\_\_\_\_  
SS #/SIN \_\_\_\_\_  
Employer \_\_\_\_\_  
Date Employed \_\_\_\_\_  
Occupation \_\_\_\_\_

Insurance Company \_\_\_\_\_  
Group # \_\_\_\_\_  
Employee/Cert. # \_\_\_\_\_  
Ins. Co. Address \_\_\_\_\_  
Deductible \_\_\_\_\_  
Amount already used \_\_\_\_\_  
Max. annual benefit \_\_\_\_\_

### Additional Insurance

Name of Insured \_\_\_\_\_  
Relationship to patient \_\_\_\_\_  
Insured's birthdate \_\_\_\_\_  
SS #/SIN \_\_\_\_\_  
Employer \_\_\_\_\_  
Date Employed \_\_\_\_\_  
Occupation \_\_\_\_\_

Insurance Company \_\_\_\_\_  
Group # \_\_\_\_\_  
Employee/Cert. # \_\_\_\_\_  
Ins. Co. Address \_\_\_\_\_  
Deductible \_\_\_\_\_  
Amount already used \_\_\_\_\_  
Max. annual benefit \_\_\_\_\_

WEI COME



Patient Name \_\_\_\_\_

Date of Birth.

## ALLERGIES - DRUG REACTIONS

Pharmacy\_\_\_\_\_

Pharmacy Phone #

Pharmacy Fax #

--(DATE)--

[illegible]

## MEDICATION LIST





# RENAL PHYSICIANS OF MONTGOMERY COUNTY, P.A.

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 . . . .	Yes	No	Parent	Sibling	Condition . . . .	Yes	No	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		

Do you use any tobacco products? ☐ Yes ☐ No

If yes, what type and how many each day? \_\_\_\_\_

Do you drink alcohol? ☐ Yes ☐ No

If yes, how many drinks each week? \_\_\_\_\_

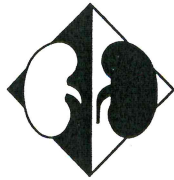
Previous Hospitalizations/Surgeries/Serious Illnesses:

When?

Hospital, City & State

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

# HEALTH HISTORY



# RENAL PHYSICIANS OF MONTGOMERY COUNTY, P.A.

200 River Pointe Dr., Ste. 120  
Conroe, TX 77304

17191 St. Luke's Way, Ste. 260  
The Woodlands, TX 77385

116 Medical Park Ln.  
Huntsville, TX 77340

425 Holderrieth Blvd., Ste. 105  
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 as 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])

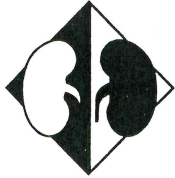
I give my permission for information to be given to the people listed above. This information can include, but is not limited to, any and all medical information, including office or hospital visits, billing and account information, appointments and medical records. I understand this information will 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)





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## 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 OF MONTGOMERY COUNTY, P.A.

FAX: 936-756-2534

Treatment Dates \_\_\_\_\_ of Medical Care.

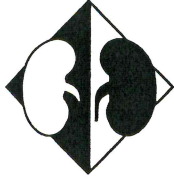
**PLEASE SEND: PHYSICIAN DICTATED OR HANDWRITTEN CONSULT OR FOLLOW-UP NOTES, DISCHARGE SUMMARY, OP REPORTS, ALL LABWORK, MRI/MRA REPORTS, U/S REPORTS, CT, EKG, CXR, ALL RADIOLOGY, URINE TEST . . . .**

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*

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**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.

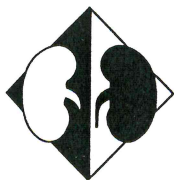
\_\_\_\_\_  
(Signature of Patient)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Personal Representative)

\_\_\_\_\_  
(Date)

\_\_\_\_\_ By initialing here, you are giving Renal Physicians of Montgomery County your permission to use your medical records for reporting purposes.



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**RPMCKidneydoc.com**

It is your responsibility to inform our office if your insurance has changed or been canceled. If you do not inform the office of any insurance changes you will be responsible for the entire cost of your visit and all of the fees and charges related to any treatments, diagnoses, or procedures performed during your visit. The office will not be responsible for resubmitting the charges if you update your insurance at a later date. It will be your responsibility to submit the proper paperwork to your insurance company to recoup any payment that had to be made.

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Signature

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Date