Mercer Renal Associates, P.A.

1345 Kuser Road, Suite 2, Hamilton, NJ 08619 – (609) 585-1344

Patient's Name _____ Birthdate (M/D/Y)_____/_____/_____

Address _____

Apartment # _____ City_____ State_____ Zip Code _____

Home Phone #(_____)_____ Cell Phone #(_____)_____

SS#(optional):_____ Preferred Language_____

Email Address_____

Sex: Female ____ Male _____ NonBinary_____ Marital Status (Please Circle): S M D W

Employment Status: Full-Time____ Part-Time_____Unemployed _____ Retired _____

Ethnicity (Hispanic, Latinx or Spanish)_____ Race_____

Allergies?_____

Emergency Contact Information

Name_____ Phone Number (_____)_____

Relationship to Patient_____

Primary Care Physician _____ Phone Number(_____)_____

Referring Physician_____ Phone Number(_____)_____

Pharmacy_____ Address: _____

Other Health Care Physicians_____

Consent for Mercer Renal Associates, PA to treat you:

Patient or Guardian Signature_____

Date_____

Past Medical History:

AFIB	**o**	**Gout**	**o**
Anemia	**o**	**Hepatitis**	**o**
Anxiety	**o**	**High Cholesterol**	**o**
Arthritis	**o**	**High Blood Pressure**	**o**
Cancer	**o**	**Kidney Disease**	**o**
Congestive Heart Failure	**o**	**Neuropathy**	**o**
COPD	**o**	**Polycystic Kidney Disease**	**o**
Coronary Artery Disease	**o**	**Retinopathy**	**o**
Deep Vein Thrombosis	**o**	**Sleep Apnea**	**o**
Depression	**o**	**Stroke**	**o**
Diabetes	**o**	**Thyroid Disorder**	**o**
GI Disorders	**o**	**UTI**	**o**

Other: _____

_____

Social History:

Do you smoke?_____ Packs per day_____ How many years?_____

If you have quit smoking, when did you quit?_____ How long did you smoke?_____

Do you drink alcohol?_____ How frequently?_____

Have you ever used illegal substances?_____ If yes, what kind?_____

Surgical History: please list any surgical procedures and the date of which they were performed, if known.

Family History:

Family Member's Relation to You Condition Living/Deceased

_____

_____

_____

_____

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- **Protected health information may be disclosed or used for treatment, payment, or healthcare operations.**
- **The practice reserves the right to change the privacy policy as allowed by law.**
- **The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.**
- **The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.**
- **The practice may condition receipt of treatment upon execution of this consent.**

May we leave a message on your answering machine at home or on your cell phone? YES NO

May we discuss your medical condition with any member of your family? YES NO

If YES, please name the members allowed:

_____

_____

This consent was signed by (Printed Name):

_____

Signature:

_____**Date:**_____