Health History

Patient Name _____ Today's Date _____

Age _____ Date of Birth _____ Date of last physical examination _____

What is your reason for visit? _____

Symptoms

Check [√] condition you currently have or have had in the past year

GENERAL
- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats

MUSCLE/JOINT/BONE

Pain, weakness, numbness:
- ☐ Arms ☐ Hips
- ☐ Back ☐ Legs
- ☐ Feet ☐ Neck
- ☐ Hands ☐ Shoulders

GERITO-URINARY
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination

GASTROINTESTINAL
- ☐ Appetite poor
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting blood

CARDIOVASCULAR
- ☐ Chest pain
- ☐ High Blood Pressure
- ☐ Irregular heart beat
- ☐ Low Blood Pressure
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Swelling of ankles
- ☐ Varicose veins

EYE, EAR, NOSE,THROAT
- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Crossed eyes
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Earache
- ☐ Ear discharge
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Vision – Flashes
- ☐ Vision – Halos

SKIN
- ☐ Bruise easily
- ☐ Hives
- ☐ Itching
- ☐ Change in moles
- ☐ Rash
- ☐ Scars
- ☐ Sore that won't heal

MEN only
- ☐ Breast lump
- ☐ Erection difficulties
- ☐ Lump in testicles
- ☐ Penis discharge
- ☐ Sore on penis
- ☐ Other

WOMEN only
- ☐ Abnormal Pap Smear
- ☐ Bleeding between periods
- ☐ Breast lump
- ☐ Extreme menstrual pain
- ☐ Hot flashes
- ☐ Nipple discharge
- ☐ Painful Intercourse
- ☐ Vaginal discharge
- ☐ Other

Date of last Menstrual Period : _____

Date of last Pap Smear : _____

Have you had a Mammogram ? _____

Are you Pregnant? _____

Number of Children: _____

Conditions

Check [√] condition you currently have or have had in the past year

- ☐ Aids
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Breast Lump
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herpes
- ☐ High Cholesterol
- ☐ HIV Positive
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Measles
- ☐ Migraine Headaches
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Problem
- ☐ Psychiatric Care
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Suicide Attempt
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Typhoid Fever
- ☐ Ulcers
- ☐ Vaginal Infections
- ☐ Venereal Disease

Allergies

_____

_____

_____

– Family History –

Relation	Age	State of Health	Age at Death	Cause of Death	Check (✓) if, your blood relatives had any of the following: Disease	Relationship to you
Father					Arthritis, Gout	
Mother					Asthma, Hay Fever	
Brothers					Cancer	
					Chemical Dependency	
					Diabetes	
					Heart Disease, Strokes	
Sisters					High Blood Pressure	
					Kidney Disease	
					Tuberculosis	
					Other	

– Hospitalizations –

Year	Hospital	Reason for Hospitalization and Outcome

Have you ever had a blood transfusion? ☐ Yes ☐ No

If yes, please give approximate dates _____

Serious Illness/Injuries	Date	Outcome

– Pregnancies –

Year of Birth	Sex of Birth	Complications if any

– Health Habits –

Check (✓) which you use and how much you use.

	Caffeine		
	Tobacco		
	Street Drugs		
	Other		

– Occupational –

Check (✓) if your work exposes you to:

	Stress		Hazardous Substances
	Heavy Lifting		Other

Occupation

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____

Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

_____ _____

Reviewed By Date

Medication List

Name: _____

Name of Medication	Dosage	Frequency

Acknowledgement of Office Policy

We would like to thank you for choosing Princeton Hypertension- Nephrology Associates as your provider. As one of our patients, we would like to keep you informed of our current office and financial policies. We require a signature to document that you have read and understand these policies.

Payment

Payment is expected at the time of service. This is an insurance company rule. This includes co-payments for participating insurance companies. We accept cash, personal checks, VISA, Discover and MasterCard. *There is an additional fee of $10.00 if co-payment is not paid at time of service*. There is a service charge of $35.00 for returned checks.

Patients with an outstanding balance more than 90 days overdue must make arrangements for payment prior to scheduling appointments. Patients are ultimately responsible for any charges or portion thereof for which payment is denied by insurance for whatever reason, except where prohibited by law or prior contractual agreement.

Insurance

Please present your insurance card at the time of your appointment. Card must be present.

We participate in most major health plans. We have contracts with many HMO's, PPO's, insurance companies and government agencies including Medicare and Medicare Managed Care. Our billing office will submit claims for any services rendered to a patient who is a member of one of these plans and will assist you in any way we reasonably can to help get your claims paid. It is the patient's responsibility to provide all necessary information at time of check in and any new insurance you may have. As a courtesy if you have a secondary insurance we will automatically file a claim with them as soon as the primary carrier has paid. Tertiary (3rd carriers) claims are the responsibility of the patient to file. If there is a balance after the primary and/or secondary pays, the patient is responsible to pay this balance in a timely fashion. It is the patient s responsibility to comply with this request.

If a patient is a member of an insurance plan with which we do not participate, payment in full is due at the time of service.

Having insurance is not a guarantee of payment and eligibility does not negate the patient s responsibility with regards to the plan policy or guidelines.

Referrals

The patient is responsible to know if his/her plan requires referral. If your plan does require referrals one must be available and valid prior to your visit. Otherwise the visit will be considered self pay and a waiver will have to be signed before seeing the doctor. Retroactive referrals are not considered as valid referrals.

Not showing up for your visit

The patient is responsible for keeping track of their appointments. We do call two days in advance as a reminder, but it is a courtesy call for our patients. We request a **48 hour notice** if you are unable to make your appointment. *There is a "No Show" fee of $100.00 for a New Patient and $50.00 for an Established Patient.*

I have read and understand this office financial policy and agree to comply and accept the responsibility for any payment that becomes due as outlined previously.

Patient Name(s) _____ Date_____

Responsible party member s name _____ Relationship_____

Responsible party member s signature _____ Date _____

Princeton Hypertension– Nephrology Associates, LLC

HIPAA AUTHORIZATION FORM

HIPAA

The ***Health Insurance Portability and Accountability Act*** of 1996 (HIPAA) is a federal law, which contains rules about how we can use your medical information with, and without, your prior permission. It also gives patients new rights with respect to the privacy of their medical information. We are obligated by law to make available to you our Notice of Privacy Practices, which explains our duties and your rights, and to get a written acknowledgement from you that you have received this information. ***The Receptionist has copies of the Notice of Privacy Practices if you would like to review them. You also can go to our website at:***
http://hypertension-nephrology.com/

To learn more about HIPAA, visit the *United States Department of Health and Human Services* website at:
http://www.hhs.gov/ocr/privacy/hipaa/administrative

☐ **I understand a copy of the Princeton Hypertension– Nephrology Associates, LLC Notice of Privacy Practices is available for my review.**

_____ _____

Patient's Signature **Date**