Princeton Hypertension– Nephrology Associates, LLC

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Welcome to our office

PLEASE PRINT ---- PLEASE PRESENT INSURANCE CARD(S) AND DRIVER'S LICENSE TO RECEPTIONIST

Patient Information

Last Name_____ First Name_____ Middle Initial_____
Social Security #_____ Date of Birth_____ ❑Male ❑Female
Address_____ City_____ State_____ Zip_____
Email Address _____ Home Phone_____ Cell Phone_____
Work Phone_____ Occupation_____ Employer/School_____

Marital Status: ❑Married ❑Single ❑Divorced ❑Widow ❑Separated **Student:** ❑Full Time ❑Part Time **Race:** ❑Amer. Indian or Alaska Native ❑Asian ❑Black or African Amer. ❑Native Hawaiian or Other Pacific Islander ❑White ❑Decline
Primary Language: ❑English ❑Spanish ❑Other ❑Decline **Ethnicity:** ❑Hispanic or Latino ❑Non-Hispanic or Latino ❑Decline

Spouse/Guarantor Info: Last Name_____ First Name_____ Middle Initial_____
Social Security #_____ Relationship_____ Date of Birth_____ ❑Male ❑Female
Address_____ City_____ State_____ Zip Code_____
Home Phone_____ Cell Phone_____

Pharmacy Information: Pharmacy Name _____**Phone** _____

Primary Insurance Company _____ Policy #_____
Group #_____ Effective Date _____ Name of Insured _____
Relationship_____ Date of Birth_____ Does your Insurance require a referral? ❑No ❑Yes

Secondary Insurance Company _____ Policy #_____
Group #_____ Effective Date_____ Name of Insured _____
Relationship_____ Date of Birth_____ Does your Insurance require a referral? ❑No ❑Yes

Emergency Contact Information: Name_____
Relationship_____ Home Phone_____ Cell Phone_____
Address _____ City_____ State_____ Zip Code_____

Primary Care Physician_____
Referred By: ❑Physician_____ **❑Self ❑Friend/Relative ❑Yellow Pages ❑Internet ❑Other**_____

I hereby authorize the release of any medical information necessary for the processing of insurance. This assignment will remain in effect until revoked by me in writing. This assignment is to be considered as valid as an original. I authorize the release of payment for services to ***Princeton Hypertension-Nephrology Associates, LLC, Drs. Michael Ruddy, Grace Bialy, Vadim Finkielstein, Seema Basi and Srujana Polsani.*** If you do not have health insurance or we do not participate with your plan, payment is expected at the time service is rendered.

Signature of Patient/Legal Guardian: _____**Date:** _____

As a service to our patients, we will assist in filing insurance and obtaining reimbursement. However, all incurred charges remain the responsibility of the patient. In order to service your account or collect monies owed, our office and/or its agents may contact you using telephone numbers associated with your account, including wireless telephone numbers which could result in charges to you. We may also contact you via text messages or e-mails. I agree to these methods of communication being used to contact me regarding my account. I agree to pay all collection agency fees (up to 33.33%), in addition to necessary attorney fees and court costs. I waive now and forever my right of exemption under the laws of the constitution of the state of New Jersey and any other state.

Signature of Patient/Legal Guardian: _____ **Date:** _____

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