

**Princeton Hypertension– Nephrology Associates, LLC**

**88 Princeton Hightstown Road, Suite 203**

**Princeton Junction, NJ 08550**

**Main # 609-750-7330 Fax # 609-750-7336**

***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

**\*If Medicare is your secondary insurance, please state why** \_\_\_\_\_

**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 Finkelstein, 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 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

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

