

# Nephrology & Hypertension Consultants, PA

## PATIENT REGISTRATION FORM

DATE \_\_\_\_\_ 20\_\_\_\_\_  
Signatures must be updated annually

PATIENT ACCOUNT NUMBER: \_\_\_\_\_  MARRIED  SINGLE  DIVORCED  WIDOWED  
Name \_\_\_\_\_ D.O.B. \_\_\_\_\_ AGE \_\_\_\_\_  MALE  FEMALE  
Address \_\_\_\_\_ Soc. Sec. No. \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ E-Mail \_\_\_\_\_  
Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Employer Phone \_\_\_\_\_  
Employer \_\_\_\_\_ Occupation \_\_\_\_\_

### EMERGENCY CONTACT

Name \_\_\_\_\_ Emp. \_\_\_\_\_  
Address \_\_\_\_\_ Emp. Phone \_\_\_\_\_  
Phone \_\_\_\_\_ Relationship \_\_\_\_\_

Authorized person(s) to release patient's medical information to: \_\_\_\_\_

REFERRING M.D. \_\_\_\_\_ PRIMARY CARE M.D. \_\_\_\_\_

PRIMARY INS. COPAY \_\_\_\_\_   
Ins. Co. \_\_\_\_\_  
Employer Name \_\_\_\_\_  
Insured's Name \_\_\_\_\_  
Insured's D.O.B. \_\_\_\_\_  
Cert. or I.D. No. \_\_\_\_\_  
Group No. \_\_\_\_\_  
Coverage Info. Tel. No. \_\_\_\_\_  
Hospital Preference or Required by this Insurance: \_\_\_\_\_  
Mail Claims to \_\_\_\_\_  
Is this an Employer Plan? \_\_\_\_\_ If yes: You or Spouse? \_\_\_\_\_  
Are you Retired? \_\_\_\_\_ Disabled? \_\_\_\_\_ Cobra? \_\_\_\_\_

PRIMARY INS. COPAY \_\_\_\_\_   
Ins. Co. \_\_\_\_\_  
Employer Name \_\_\_\_\_  
Insured's Name \_\_\_\_\_  
Insured's D.O.B. \_\_\_\_\_  
Cert. or I.D. No. \_\_\_\_\_  
Group No. \_\_\_\_\_  
Coverage Info. Tel. No. \_\_\_\_\_  
Hospital Preference or Required by this Insurance: \_\_\_\_\_  
Mail Claims to \_\_\_\_\_  
Is this an Employer Plan? \_\_\_\_\_ If yes: You or Spouse? \_\_\_\_\_

I acknowledge the opportunity to review NHC's Notice of Privacy Practices.

**AUTHORIZATION FOR TREATMENT:** I hereby authorize such examinations, treatments, and medications, as may be prescribed by the Nephrology & Hypertension Consultants, P.A. physician in charge of my care. **AUTHORIZATION TO RELEASE INFORMATION:** I authorize the physicians of NHC, PA to release any information required in the course of my treatment for insurance purposes. **AUTHORIZATION OF PAYMENT POLICY:** I understand that I am responsible for all medical expenses regardless of insurance coverage. **ASSIGNMENT OF BENEFITS:** I authorize payment directly to Nephrology & Hypertension Consultants, PA for any medical or Medicare benefits payable to me for services rendered.

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

**NEPHROLOGY AND HYPERTENSION CONSULTANTS, P.A.**  
**PATIENT QUESTIONNAIRE**

Today's date \_\_\_\_\_

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

Primary Physician: \_\_\_\_\_ Phone #: \_\_\_\_\_

Other physicians: \_\_\_\_\_

Pharmacy Name/Address/Phone: \_\_\_\_\_

**PAST MEDICAL HISTORY**

**Check (v) conditions you have or have had.**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Diabetic Eye Disease | <input type="checkbox"/> Cancer        |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Hepatitis            | <input type="checkbox"/> Gout          |
| <input type="checkbox"/> Kidney Disease      | <input type="checkbox"/> Protein In Urine     | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Kidney Stones       | <input type="checkbox"/> High Cholesterol     | <input type="checkbox"/> Lupus         |
| <input type="checkbox"/> Kidney Transplant   | If yes, Date: _____                           |  |

List other conditions or illnesses you have: \_\_\_\_\_

**YOUR FAMILY HISTORY**

**Check (v) medical conditions that run in your family (besides yourself):**

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Diabetes       | <input type="checkbox"/> Heart Disease     | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Bleeding Problems | <input type="checkbox"/> Cancer              |

List other conditions that run in your family: \_\_\_\_\_

**MEDICATION**

List the name, dosage, frequency and reason of all medications you are currently taking.  
 Please list all over-the-counter medications also. Use back of this form if you need more space.

Medication Name	Dosage (mg, units?)	Frequency	Reason

List all allergies (including environmental, food, and medications) with your reaction to exposure.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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

Place a check (v) in circle of any symptoms you have had in the past 3 weeks:

<b><u>Constitutional</u></b>		<b><u>Vascular</u></b>		<b><u>Metabolic/Endocrine</u></b>	
Change in appetite	<input type="checkbox"/>	Blue/gray skin	<input type="checkbox"/>	Excessive thirst	<input type="checkbox"/>
Chills and fever	<input type="checkbox"/>	Cold extremities	<input type="checkbox"/>	Insulin reaction	<input type="checkbox"/>
Fatigue / weakness	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	Low blood sugar	<input type="checkbox"/>
Irritability	<input type="checkbox"/>	Varicose veins	<input type="checkbox"/>	Numbness/tingling	<input type="checkbox"/>
Night sweats	<input type="checkbox"/>			Problems with cold	<input type="checkbox"/>
Sleep Problems	<input type="checkbox"/>	<b><u>GI</u></b>		Problems with heat	<input type="checkbox"/>
Weight Loss	<input type="checkbox"/>	Abdominal pain	<input type="checkbox"/>	Weight gain	<input type="checkbox"/>
		Blood in stool	<input type="checkbox"/>		
		Constipation	<input type="checkbox"/>	<b><u>Neurological/Psych</u></b>	
<b><u>HEENT</u></b>		Diarrhea	<input type="checkbox"/>	Tremors	<input type="checkbox"/>
Headache	<input type="checkbox"/>	Heartburn	<input type="checkbox"/>	Seizures	<input type="checkbox"/>
Hearing problems	<input type="checkbox"/>	Hemorrhoids	<input type="checkbox"/>	Difficult speech	<input type="checkbox"/>
Mouth problems	<input type="checkbox"/>	Nausea	<input type="checkbox"/>	Difficult walking	<input type="checkbox"/>
Nasal problems	<input type="checkbox"/>	Swallowing issues	<input type="checkbox"/>	Memory problems	<input type="checkbox"/>
Throat problems	<input type="checkbox"/>	Vomiting	<input type="checkbox"/>		
Visual problems	<input type="checkbox"/>			<b><u>Dermatological</u></b>	
		<b><u>GU</u></b>		Rash	<input type="checkbox"/>
<b><u>Respiratory</u></b>		Blood in urine	<input type="checkbox"/>	Itching	<input type="checkbox"/>
Cough	<input type="checkbox"/>	Decreased urine	<input type="checkbox"/>	Skin eruptions	<input type="checkbox"/>
Difficult breathing	<input type="checkbox"/>	Foul urine odor	<input type="checkbox"/>	Skin infection	<input type="checkbox"/>
Shortness of breath	<input type="checkbox"/>	Frequent urination	<input type="checkbox"/>	Unusual sweating	<input type="checkbox"/>
		Leaking urine	<input type="checkbox"/>		
<b><u>Cardiovascular</u></b>		Painful urination	<input type="checkbox"/>	<b><u>Musculoskeletal</u></b>	
Chest pain	<input type="checkbox"/>	Slow urine stream	<input type="checkbox"/>	Back pain	<input type="checkbox"/>
Fainting	<input type="checkbox"/>	Urination at night	<input type="checkbox"/>	Muscle cramps	<input type="checkbox"/>
Irregular heart beat	<input type="checkbox"/>			Muscle weakness	<input type="checkbox"/>
Swelling	<input type="checkbox"/>	<b><u>Reproductive</u></b>		Neck Stiffness	<input type="checkbox"/>
		Last menstruation	<input type="checkbox"/>	Painful joints	<input type="checkbox"/>
<b><u>Hematologic</u></b>		Difficult period	<input type="checkbox"/>		
Bleeding	<input type="checkbox"/>	Impotence	<input type="checkbox"/>	<b><u>Immunological</u></b>	
Bruising easily	<input type="checkbox"/>	Other	<input type="checkbox"/>	Allergies	<input type="checkbox"/>

Comments: \_\_\_\_\_

List reasons for hospitalizations, dates of admission, name of hospital.

Use back of this form if more space is needed.

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

**SOCIAL HISTORY**

Race: \_\_\_\_\_ Ethnicity:  Hispanic/Latino  Not Hispanic/Latino  Other  
Primary language spoken: \_\_\_\_\_ Language spoken at home: \_\_\_\_\_  
Birthplace: \_\_\_\_\_ Hand dominance (right/left) \_\_\_\_\_  
List any social issues you would like to discuss: \_\_\_\_\_

**Family / Social Support**

Do you have children? Yes / No Number of girls: \_\_\_\_\_ boys: \_\_\_\_\_  
Who lives with you? \_\_\_\_\_ Relationship? \_\_\_\_\_  
Who comprises your support network? \_\_\_\_\_

**Education / Military Experience**

Highest level of education obtained: 9 10 11 12 GED AA/AS BA/BS MA/MS Ph.D. MD \_\_\_\_\_  
Occupational hazards: \_\_\_\_\_ Military experience: \_\_\_\_\_ Branch: \_\_\_\_\_

**Tobacco**

Do you use tobacco? Yes / No  
What kind? \_\_\_\_\_ Amount per day: \_\_\_\_\_ How many years? \_\_\_\_\_  
Have you ever tried to quit? \_\_\_\_\_  
Passive smoke exposure: \_\_\_\_\_ How: \_\_\_\_\_

**Alcohol**

Do you consume alcohol? Yes / No  
Type: \_\_\_\_\_ Frequency: \_\_\_\_\_ Amount: \_\_\_\_\_  
When was your last drink? \_\_\_\_\_

**Caffeine**

Do you consume caffeine? Yes / No  
Type (check all that apply):  chocolate  coffee  soda  tea  \_\_\_\_\_  
Amount per day: \_\_\_\_\_

**Lifestyle**

Have you had sleep pattern changes? Yes / No Explain: \_\_\_\_\_  
Activity level:  inactive  moderate  vigorous  \_\_\_\_\_  
Type of exercise: \_\_\_\_\_ Frequency: \_\_\_\_\_  
Hobbies/Activities: \_\_\_\_\_  
Diet History: \_\_\_\_\_  
Do you have animals in your home? Yes / No What kind: \_\_\_\_\_  
Within the past 2 years, have you traveled out of state? Yes / No Out of country? Yes / No  
Where? \_\_\_\_\_

**If necessary, would you agree to a blood transfusion?** Yes / No

**Advance Directives In Place** (Check all that apply)

None  Healthcare Proxy  Living Will  DNR  Durable Power of Attorney

**NEPHROLOGY AND HYPERTENSION CONSULTANTS, P.A.**

**FINANCIAL POLICY**

It is the goal of Nephrology and Hypertension Consultants to provide you with the finest of medical care available at a cost that is both fair and reasonable. Your understanding of our financial policy is essential.

The following is our Financial Policy, which we require that you read and sign prior to treatment.

- Self-pay patients are expected to pay for services received in full at the time of service. Any financial arrangements must be made before you see the physician.
- We cannot file your insurance if you do not have a copy of your insurance card or the necessary insurance information. You will need to present your current insurance card/s at each visit. Errors and changes in policy coverage prevent us from filling insurance with only a policy number and company name. Without a copy of your insurance card, we must have the insurance company's name and phone number to verify benefits, policyholder's name, and insurance identification number. Without this information, your account will be treated as self-pay. (see above)
- If your health plan requires a referral or authorization from your primary care physician, we will need to receive the authorization before you see our physician. If we have not received an authorization prior to your arrival at our office, you will be considered self-pay. We will refund you when we receive proper authorization for those services.
- As a courtesy to you, we will file charges with your insurance company. Charges not paid by your insurance company within 90 days will become due and payable you unless you have Medicare, Medicaid, or insurance policy in which we participate.
- All co-payment, co-insurance, and deductible amounts are due at the time of service. This is an insurance requirement. We accept cash, check, and participating check and major credit cards when possible.
- In the event your health insurance determines a service is "not covered", you will be responsible for payment. We try to inform patients when services may not be covered; however, it is the patient's responsibility to understand his/her policy limitations.
- In order for us to accept and file Medicaid, we must have a CURRENT Medicaid card on file for each visit.
- We will bill for workers compensation services that have been pre-authorized by your employer or work comp insurance carrier. You will receive a statement from this office to keep you informed. After 90 days, these charges become your responsibility. It is important to follow closely with your employer to make certain these charges are paid in a timely manner.
- A \$25.00 service charge plus any and all bank charges will be applied to your account for any returned check. Once a check has been returned, we can only accept cash.

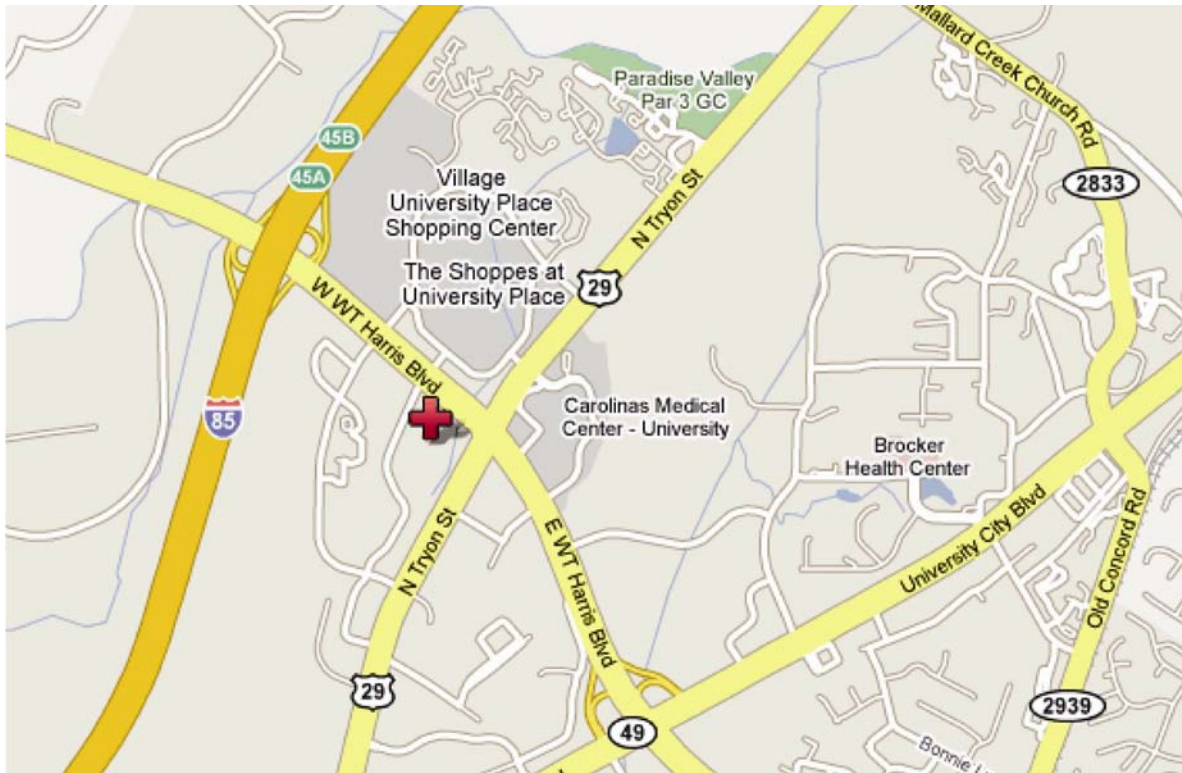
Please be aware that any unpaid balance over 90 days is subject to intensive collection procedures.

We understand that financial problems arise from time to time. Please let us know if you need to arrange a payment plan that allows you to pay off your balance in installments. Our billing staff can assist you with these arrangements.

Effective date: Once you have signed this agreement, you agree to all the terms and conditions contained herein and the agreement will be in full force.

Name of patient: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Signature of Patient / Guardian: \_\_\_\_\_ Date: \_\_\_\_\_



**Nephrology and Hypertension Consultants, PA  
8430 University Executive Park Drive, Suite 685  
Charlotte, North Carolina 28262  
Phone: (704) 503-4400**

**From: Harrisburg, NC**—Take Hwy 49 South 5 1/2 miles. Turn right onto WT Harris Blvd., traveling West. Continue West on WT Harris Blvd. 1 mile. Turn left on to University Exec. Park Drive. Go 0.3 miles. Turn left into Building 8430. Drive between the fountain and the building to the last office, Suite 685.

**From: Concord/Kannapolis, NC**—Take I85 South 13 miles to WT Harris Blvd. Exit 45 A onto WT Harris Blvd traveling East. Go 1/2 mile. Turn right onto University Exec. Park Drive. Go 0.3 miles. Turn left into building 8430 at first entrance. Drive between the fountain and the building to the last office Suite, 685.

**From: Matthew/Monroe, NC**—Take Hwy 74 West to I485. Continue East and North onto I485 for 18 miles. Exit onto I-85 going south. Go 3 miles and take exit 45A onto WT Harris Blvd. traveling East. Continue East on WT Harris Blvd 1/2 mile. Turn right onto University Exec. Park Drive. Go 0.3 miles. Turn left into Building 8430. Drive between the fountain and the building to the last office, Suite 685.

**From: West Charlotte**—Take I85 North. Continue to exist 45 A, WT Harris Blvd. Go East on WT Harris Blvd 1/2 mile. Turn right onto University Exec. Park Drive. Go 0.3 miles. Turn left into Building 8430. Drive between the fountain and the building to the last office, Suite 685.

**From: I77 South**—Travel I77 North to I85 exit. Take I85 North to exit 45A. Travel East on WT Harris Blvd 1/2 mile. Turn right onto University Exec. Park Drive. Go 0.3 miles. Turn left into Building 8430. Drive between the fountain and the building to the last office, Suite 685.

**From: I77 North, Cornelius, NC**—Take I77 South to WT Harris Blvd. Go East on WT Harris Blvd approximately 9 miles (cross over I85). Go 1/2 mile and turn right onto University Exec. Park Drive. Go 0.3 miles. Turn left into Building 8430. Drive between the fountain and the building to the last office, Suite 685.