Nephrology & Hypertension Associates, P.C.

Sina Raissi MD Mira Rho MD Monzurul H. Chowdhury MD Marilyn Olsen PA-C Oltjon Albajrami MD

PATIENT NAME:___________________________________ DATE OF BIRTH:_____________

SOCIAL SECURITY #:____________________________ MALE ◯ FEMALE ◯

ADDRESS:____________________________ APT#:_________ CITY:______________________

STATE:_________ ZIPCODE:______________ EMAIL:_______________________________

HOME TELEPHONE:________________________ CELL TELEPHONE:___________________

EMPLOYER:___________________________ WORK TELEPHONE:________________________

IF UNEMPLOYED, PLEASE CHECK THE APPROPRIATE BOX:

RETIRED ◯ DISABLED ◯ STUDENT ◯ OTHER ◯ _______________

EMERGENCY CONTACT AND RELATION:____________________________________

PHONE#:___________________________

REFERRING PHYSICIAN:_________________________ PHONE:________________________

PRIMARY CARE PHYSICIAN:_________________ PHARMACY:________________________

ETHNICITY: NOT HISPANIC OR LATIN◯ HISPANIC OR LATIN◯ NO ANSWER◯

RACE: AMERICAN INDIAN/ ALASKA NATIVE◯ ASIAN◯ AFRICAN AMERICAN◯

NATIVE HAWAIIAN◯ HISPANIC◯ MORE THAN ONE RACE◯ OTHER PACIFIC ISLANDERS◯ WHITE LATINO ◯ UNREPORTED/ REFUSE TO REPORT◯

LANGUAGE:________________________________

PLEASE PRESENT INSURANCE CARDS AT THE TIME OF VISIT TO AVOID ANY UNNECESSARY CHARGES TO YOUR ACCOUNT. CO-PAYS ARE EXPECTED UPON ARRIVAL OF YOUR VISIT

I AUTHORIZE THE RELEASE OF ANY INFORMATION CONCERNING MY HEALTH CARE, ADVICE, AND/OR TREATMENT PROVIDED FOR THE PURPOSE OF EVALUATING AND ADMINISTERING CLAIMS FOR INSURANCE BENEFITS. I ALSO HEREBY AUTHORIZE PAYMENT OF INSURANCE BENEFITS OTHERWISE PAYABLE TO ME DIRECTLY TO THE DOCTOR. IN THE EVENT OF NONPAYMENT THROUGH INSURANCE OR OTHERWISE, I ACCEPT FULL RESPONSIBILITY FOR ANY BALANCES OWED. NEPHROLOGY AND HYPERTENSION ASSOCIATES MAY ALSO PROVIDE INFORMATION THEY OR THEIR AGENTS MAY DEEM APPROPRIATE TO MY PHYSICIANS OR ATTORNEY CONCERNING MY ILLNESS, TREATMENT, AND/OR PROGNOSIS.

SIGNATURE OF PATIENT OR LEGAL GUARDIAN

SIGNATURE:______________________________________ DATE:___________________