OCEAN RENAL ASSOCIATES, P.A.

Brick Office	Toms River Office	Manahawkin Office	Neptune Office
210 Jack Martin Blvd. Suite D-1 Brick, NJ 08724 P: 732-458-5854 F:732-458-8012	508 Lakehurst Rd. Suite 3A Toms River, NJ 08755 T: 732-341-4600 F:732-341-4993	1301 Rt 72 West Suite 206 Manahawkin, NJ 08050 P:609-978-9940 F:609-978-9902	444 Neptune Blvd. Suite 5 Neptune, NJ 07753 P:732-774-4220 T: 732-774-0690

For:_____

Your Appointment Date:_____

With:_____

Please make sure you have with you your:

- **Completed New Patient Demographic Form**
- **Insurance Card(s)**
- **Referral if needed**
- **Photo ID**
- **Any Labs or Radiological Testing you've had done.**

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NORTHEAST KIDNEY CARE

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Patient Name:_____ _____
(Last) (First) (Middle)

Birth Date:_____/_____/_____ Social Security #:_____/_____/_____ Age: _____

Gender: (circle) Male - Female Language Preference:_____

Cell #:_____ Home #:_____

Emergency Contact:_____ Emerg. Contact Number:_____

Relationship to Contact:_____ Marital Status:_____

Email: _____ Ethnicity/Race: _____

Home Address:_____
(Number) (Street) (Apt #) (City) (State) (Zip Code)

Primary Care Physician:_____ Tele Number:_____

Referring Physician: _____ Tele Number:_____

Preferred Pharmacy:_____ Pharm Number:_____

INSURANCE INFORMATION

Primary Insurance:_____

Subscriber Name:_____

Subscriber Birth Date:_____/_____/_____ Effective Date: _____/_____/_____
(Mo) (Day) (Year)

ID #:_____ Group/Policy#:_____

Insurance Address:_____
(Number) (Street) (Suite #) (City) (State) (Zip Code)

Secondary Insurance:_____

Subscriber Name:_____

Subscriber Birth Date: _____/_____/_____ Effective Date: _____/_____/_____
(Mo) (Day) (Year)

ID #:_____ Group/Policy#:_____

Insurance Address:_____
(Number) (Street) (Suite #) (City) (State) (Zip Code)

□ **INSURANCE ASSIGNMENT & RELEASE**: I certify that I (or my dependents) have insurance coverage with the above listed companies and assign directly to Ocean Renal Associates all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am personally responsible for all financial charges whether or not paid by the insurance company. I authorize the use of my signature of all insurance submissions. Ocean Renal Associates may use my health care information and may disclose such information to the above named insurance company(ies), and their agents for the purposes of obtaining payment for services rendered and determining insurance benefits, or the benefits payable for related services.

Signature of Beneficiary, Guardian or Representative:_____

PRINT NAME_____DATE:_____/_____/_____

HISTORY FORM

MEDICAL HISTORY:

Please Circle Medical Problems Listed Below
(Please Include The Duration or Date The Medical Problem Was Diagnosed)

1. Diabetes
2. COPD/Lung Disease
3. Cancer
4. High Blood Pressure
5. Leg Swelling/Edema
6. Lupus
7. Kidney Disease
8. Polycystic Kidney Disease
9. Hepatitis B or C
10. High Cholesterol
11. Gout
12. Protein in Urine
13. Blood in Urine
14. Heart Attack
15. Congestive Heart Failure
16. HIV/AIDS
17. Kidney Stones
18. Liver Disease
19. Enlarged Prostate
20. Recurrent Urinary Tract Infections

Please List Other Medical Problems Not Listed Above:

_____

_____

_____

_____

SURGICAL HISTORY:

Please Circle Procedures/Surgeries Listed Below
(Please Include The Date/Location The Procedure Was Performed)

1. Kidney Artery Stent
2. Kidney Removal/Surgery
3. Kidney Biopsy
4. Bypass Surgery
5. Colon Surgery
6. Leg Bypass Surgery
7. Angioplasty
8. Carotid Surgery
9. Bladder Surgery
10. Coronary Stent
11. Eye/Laser Surgery
12. Cystoscopy
13. Heart Valve Surgery
14. Prostate Surgery
15. Urinary Stent Placement
16. Amputation
17. Gallbladder Surgery
18. Bladder Surgery
19. Weight Loss Surgery
20. Joint Replacement

Please List Other Procedures/Surgeries Not Listed Above:

_____

_____

_____

FAMILY HISTORY

Relationship	No Known Problems	Anemia	Cancer	Diabetes	High Blood Pressure	Kidney Disease	Stroke	Dementia	Gout	Heart Disease	Polycystic Kidney Disease
Mother											
Father											
Sister											
Brother											
Maternal Grandfather											
Maternal Grandmother											
Paternal Grandfather											
Paternal Grandmother											
Children											

MEDICATION LIST

Medication Name	Dose	Directions
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		

SOCIAL HISTORY

Smoking History

_____ Cigs/Packs (Circle) Per Day Total Years _____ Still Smoke: □ Yes □ No

Tried to Quit: □ Yes □ No Quit Date: ___/_____/____ Want to Quit:□ Yes □ No

Drug History

Drug Use □ Yes □ No Type of Drug(s) _____ Still Using: □ Yes □ No

Tried to Quit: □ Yes □ No Quit Date: ___/_____/____ Want to Quit:□ Yes □ No

Alcohol History

_____ Drinks Per Day Total Years _____ Still Drink: □ Yes □ No
c

Tried to Quit: □ Yes □ No Quit Date: ___/_____/____ Want to Quit:□ Yes □ No

Personal History

Occupation:_____ Retired: □ Yes □ No If Yes, When? _____

Married: □ Yes □ No Divorced: □ Yes □ No Widowed: □ Yes □ No Single: □ Yes □ No

Living Arrangement: □ Alone □ Spouse □ Sig. Other □ Family Mbr □ In HomeCare

Deficits: □ Hearing Loss □Poor Vision/Blindness □ Limited Mobility □Transport Issues

History of Blood Transfusions: □ Yes □ No If Yes, When? _____

History of NSAID Use (Advil/Motrin/Aleve/Ibuprofen Etc..): □ Yes □ No

Please List Any Known Allergies

_____

_____

HIPAA Privacy Authorization Form

The HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosure of their protected health information. It is intended to provide a standard for certain health care providers to obtain their patient's consent for uses and disclosures of health information about the patient to carry out treatment, payment or health care options. As our patient, we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy.

Healthcare entities must keep records of protected health information disclosures. Information provided below, if completed properly, will constitute an adequate record.

Please list any family members to whom medical information can be disclosed.

Name:	**Relationship:**	**Number:**
Name:	**Relationship:**	**Number:**
Name:	**Relationship:**	**Number:**
Name:	**Relationship:**	**Number:**

This medical information may be used by the persons I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

I understand that I have the right to revoke this authorization, in writing, at any time.

_____

Patient Signature **Date**

_____

Patient Name **Date of Birth**

SSN:_____

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