Nephrology & Hypertension Associates, P.C.

Sina Raissi, MD Mira Rho, MD Monzurul H. Chowdury, 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: CAUCASIAN◯ 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 OR 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:_____