SOUTHWEST VIRGINIA
Nephrology Medicine PC

SOUTHWESTVIRGINIA NEPHROLOGY MEDICINE

PATIENT REGISTRATION FORM

Referring Physician: _____ Phone #: (_____) _____-_____

Patient Information:

Title: (Please Circle) Dr. Mr. Mrs. Ms. Miss. Marital Status: _____

Last name: _____ First Name: _____

Middle Name: _____ Sex: (Please Circle) Male/Female

Date of Birth Date: ____-____-_____ Social Security #: __ __ - __ __ __- __ __ __ __

Race: (Please Circle) Caucasian, American Indian, Asian, Black or African American, Native Hawaiian or other Pacific Islander

Patient Contact Information:

Address: _____

City: _____ State: _____ Zip: _____

Home Phone#: (_____) _____-_____ Cell Phone#: (_____) _____-_____

Email Address: _____

Employer Name: _____ Phone#: (_____) _____-_____

Employer Address: _____

City: _____ State: _____ Zip: _____

Spouse: _____ Phone#: (_____) _____-_____

Emergency Contact: _____ Phone#: (_____) _____-_____

Relationship to Patient: _____

Primary Insurance: _____ Policy Holder: _____

Responsible Party:

Guarantor's Name: _____ Phone#: (_____) _____-_____

Guarantor DOB: ____-____-_____ Guarantor SSN#: __ __ - __ __ __- __ __ __ __

Address: _____

City: _____ State: _____ Zip: _____

Patient Relationship to Guarantor: _____ Guarantor Employer: _____

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Patient Name: _____ Date of Birth Date: ____-____-_____

Past Medical History:

Yes No Diabetes
Yes No High Blood Pressure
Yes No Stroke
Yes No Seizure Disorder
Yes No Heart Disease
Yes No Heart Murmur
Yes No Heart Rhythm Disturbance
Yes No Emphysema/COPD
Yes No Asthma
Yes No Blood Clots Legs or Lungs Yes No Sleep Apnea
Yes No Gastrointestinal Bleeding
Yes No Liver Disease or Hepatitis
Yes No Thyroid Trouble
Yes No Cancer
Yes No Have you ever had a blood transfusion?
Yes No HIV Infection
Yes No Tuberculosis
Yes No Lupus

Other Medical History (Please Specify):

_____

_____

_____

_____

_____

_____

_____

Surgeries:

_____

_____

_____

_____

_____

_____

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Patient Name: _____ Date of Birth Date: ____-____-_____

Your Contact information:

Below are the phone numbers we have on file to contact you. Please circle yes or no if we are able to leave messages for you at the following numbers:

Home#: (_____) _____-_____ Yes/No Work#: (_____) _____-_____ Yes\No

Cell#: (_____) _____-_____ Yes/No

Emergency Contact#: (_____) _____-_____ Yes\No

Name: _____ Relationship: _____

Which contact number would you prefer our office staff to use when trying to reach you between 8 am and 4 pm on weekdays? (Circle one)

Home Work Cell Emergency

Providers:

Referring Physician: _____ Phone #: (_____) _____-_____

Primary Care Physician: _____ Phone #: (_____) _____-_____

Are there other providers you see routinely that are not listed above that you feel we should obtain records from for your visit? (For example) Cardiologist, Endocrinologist, etc.) If so list their name and phone number below.

_____

_____

_____

_____

Pharmacy:

Which pharmacy to you use to fill most of your prescriptions?

Pharmacy Name: _____

Employer Address: _____

Pharmacy Phone#: (_____) _____-_____ Pharmacy Fax Phone#: (_____) _____-_____

Signature:_____ Date: ____-____-_____

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Patient Name: _____ Date of Birth Date: ____-____-_____

Medications:

(Please list all prescription, over the counter medications, vitamins and herbals)

Name Dose (mg,mcg,ml,etc) Frequency (daily, etc)

Allergies:

Miscellaneous:

(Please provide any other information that is relative to your case)

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Patient Name: _____ Date of Birth Date: ____-____-_____

Release of Medical Information and Authorizations:

- **I hereby authorize Southwest Virginia Nephrology Medicine to release medical information to any of my physicians or insurance companies that may be pertinent to my case.**
- **I hereby authorize payment directly to Southwest Virginia Nephrology Medicine of benefits otherwise payable to me.**
- **I hereby authorize the release of medical records to third party insurers or other authorized persons to whom disclosure is necessary to establish or collect a fee for the service.**
- **I understand that I am financially responsible for the charges not covered by this authorization, A photocopy of this authorization shall be valid as the original.**
- **I certify that I have read and fully understand the above statement and consent fully and voluntarily to its contents.**

Patient's Signature (or responsible party): _____

Printed name of patient or personal representative: _____

Relationship to patient: _____ Date: ____-____-_____

I request and authorize Southwest Virginia Nephrology Medicine to disclose protected health care information to the individual(s) below:

Contact 1 Name: _____ Phone#: (_____) _____-_____

Contact 2 Name: _____ Phone#: (_____) _____-_____

Contact 3 Name: _____ Phone#: (_____) _____-_____

I acknowledge the practice has provided me a copy of its notice of Privacy Practices, which provides a detailed description of the disclosures allowed by this consent, as well as other rights I have regarding my protected health information.

Patient's Signature (or responsible party): _____

Printed name of patient or personal representative: _____

Relationship to patient: _____ Date: ____-____-_____

I consent to Southwest Virginia Nephrology Medicine using or disclosing my protected health information for the purpose of giving treatment to me, obtaining payment for health care services rendered to me or to carry out Practice's health care activities provided by another provider or entity, I further consent to the disclosure of my protected health information to another provider or health care entity to conduct health care operations including quality assessment and reviewing the practice of health care professionals

Patient's Signature (or responsible party): _____

Printed name of patient or personal representative: _____

Relationship to patient: _____ Date: ____-____-_____