



# SOUTHWEST VIRGINIA 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: \_\_\_\_ - \_\_\_\_ - \_\_\_\_\_ 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: \_\_\_\_\_

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):***

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***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.

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***Pharmacy:***

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

Pharmacy Name: \_\_\_\_\_

Employer Address: \_\_\_\_\_

Pharmacy Phone#: (\_\_\_\_) \_\_\_\_ - \_\_\_\_

Pharmacy Fax#: (\_\_\_\_) \_\_\_\_ - \_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_ - \_\_\_\_ - \_\_\_\_



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: \_\_\_\_ - \_\_\_\_ - \_\_\_\_