Renal Physician Associates of Winchester

Patient Information:

Date: _____ Name (Last, First, M): _____

Address: _____
Street City State Zip Code

Home#: _____ Cell#: _____ Primary Care Physician: _____

Social Security Number: _____-_____-_____ Birth Date: _____/_____/_____ Sex: (M / F)

Email: _____ Marital Status: (Single / Mar / Div / Sep / Wid)

Employer (of insured party): _____ Employer Phone: _____

Race: (Caucasian / African American / Indian / Hispanic) Preferred Language: _____

Insurance Information:

Primary Insurance: _____

Policy #: _____ Group #: _____

Policy Holder Name: _____ DOB: _____ SSN: _____-_____-_____

Patient Relationship to Policy Holder: _____

Secondary Insurance: _____

Policy #: _____ Group #: _____

Policy Holder Name: _____ DOB: _____ SSN: _____-_____-_____

Patient Relationship to Policy Holder: _____

Emergency Contact:

Name: _____

Phone (Home): _____ (Cell): _____

Relationship to Patient: _____

I hereby authorize Renal Physician Associates to examine and prescribe me such treatment(s) as deemed necessary or advisable based on my diagnosis. I hereby authorize Renal Physician Associates to release any information acquired in the course of my examination or treatment to the insurance company. I understand that Renal Physician Associates will file my insurance claim as a courtesy and I authorize my insurance benefits to be paid directly to Renal Physician Associates. This authorization shall remain valid until revoked in writing.

_____ _____
Signature Date

812 Amherst Street, Ste. 201 • Winchester, VA 22601 • (540) 450-1600 • Fax: (540) 450-0166

Renal Physician Associates of Winchester

Patient Name:_____ **Date of Birth:** _____

Current Providers: Please list the name of your providers you see routinely (example: Cardiologist, etc.)

_____

_____

_____

_____

Pharmacy:

Pharmacy Name: _____ Pharmacy Phone Number: _____

Pharmacy Address: _____ Pharmacy Fax: _____

PRIOR SURGERIES AND HOSPITALIZATIONS: (Please list all prior operations)

SURGERY	DATE	SURGERY	DATE
Appendectomy		Hemorrhoidectomy	
CABG/Heart Bypass		Hernia Repair	
Cataract Left Right Both		Hip Replacement Left Right Both	
D&C		Knee Replacement Left Right Both	
Gall Bladder Removal		Hysterectomy	
Gastric Bypass		Prostatectomy	
		Nephrectomy	
Renal Transplant		Thyroidectomy	
Tonsillectomy		Valve Replacement	
AV Fistula		PD Cath	
Other:		Other:	

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Financial Policy

Our practice accepts most insurances. We expect all co-pays to be paid at the time of service. If you are uninsured all payments are due at the time of services.

We will bill your insurance, as a courtesy, for your reimbursement. We accept, VISA, Mastercard, and Discover for you convenience. As a courtesy we will also bill your secondary insurance. Extenuating financial circumstances will be handled in a confidential matter between the patient, the physician and the patient service representative.

If your insurance is a HMO (Health Maintenance Organization) or EPO (Exclusive Provider Organization), it is your responsibility to first obtain the required authorization from your Primary Care Provider (PCP) prior to the appointment and present the authorization at the reception desk before seen by the physician.

It is YOUR responsibility to know your insurance. You should know your policies:

- Contracted Providers
- Need for prior authorization
- Specific facilities for labs and x-rays
- Co-payment amount
- Your yearly deductible

We reserve the right to charge $25.00 for missed appointments without notice to the office.

I have read this Financial Policy and consent to being responsible for any unpaid medical bill for services received.

Patient/Patient Representative (Print)	Relationship	Date
Patient/Patient Representative (Signature)	Relationship	Date

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MEDICAL HISTORY

Use the space below to provide details and/or year of onset.

Kidney Disease

Stage (if known):_____

Transplant Year:_____Where:_____

Type: Living Relative Living Unrelated

Dialysis Year:_____

Type: Peritoneal Dialysis Hemodialysis

COMPREHENSIVE PATIENT MEDICAL HISTORY

Diabetes Type 1 _____

Diabetes Type 2 _____

Diabetes Type Unknown _____

Gout _____

High Blood Pressure _____

Heart Disease	Year
Heart Attack Angina	
Atrial Fibrillatory Pacemaker	
Heart Valve Disease	
Congestive Heart Failure Defibrillator	
Angioplasty/Stent	

CANCER	YEAR	CANCER	YEAR
Kidney		Lymphoma	
Breast		Melanoma	
Prostate		Thyroid	
Colon		Leukemia	
Lung		Uterine	
Bladder		Pancreatic	
Testicular		Other	

ENT	Year
Blindness	
Cataracts	
Glaucoma	
Hearing Problems	

Genitourinary	Year
Kidney Stones	
Enlarged Prostate	
Frequent UTI's	

Neurological	Year
Neuropathy	
Seizures	
Multiple Sclerosis	
Stoke	
Parkinson's Disease	
Dementia	
Migraines/Headaches	

Psychiatric	Year
Depression	
Anxiety Disorder	

Musculoskeletal	Year
Osteoarthritis	
Osteoporosis	

Hematology	Year
Anemia	
Blood Infusions	
Sickle Cell Anemia	
Sickle Cell Trait	

Gastrointestinal	Year
Acid Reflux	
Hepatitis Type	
Irritable Bowel Syndrome	
Stomach Bowel Ulcers	
Inflammatory Bowel Disease	
Ulcerative Colitis/Crohn's Disease	

Respiratory	Year
COPD	
Emphysema	
Chronic Bronchitis	
Asthma	
Pneumonia	
Sleep Apnea	
TB	

Endocrine	Year
Hypothyroidism	
Hyperthyroidism	
Adrenal	

Immune/Rheumatology	Year
Lupus	
Rheumatoid Arthritis	
HIV	

OB History	Year
Preeclampsia	
Pregnancy Induced Hypertension	
Gestational Diabetes	
Hx of Difficulty Pregnancies	

MEDICATION INFORMATION

MEDICATIONS: (Prescription and over-the-counter medications, vitamins, birth control pills, herbs and supplements.)

MEDICATION	DOSE	FREQUENCY

Drug Allergies: (Please list any medications you are allergic too.)

_____

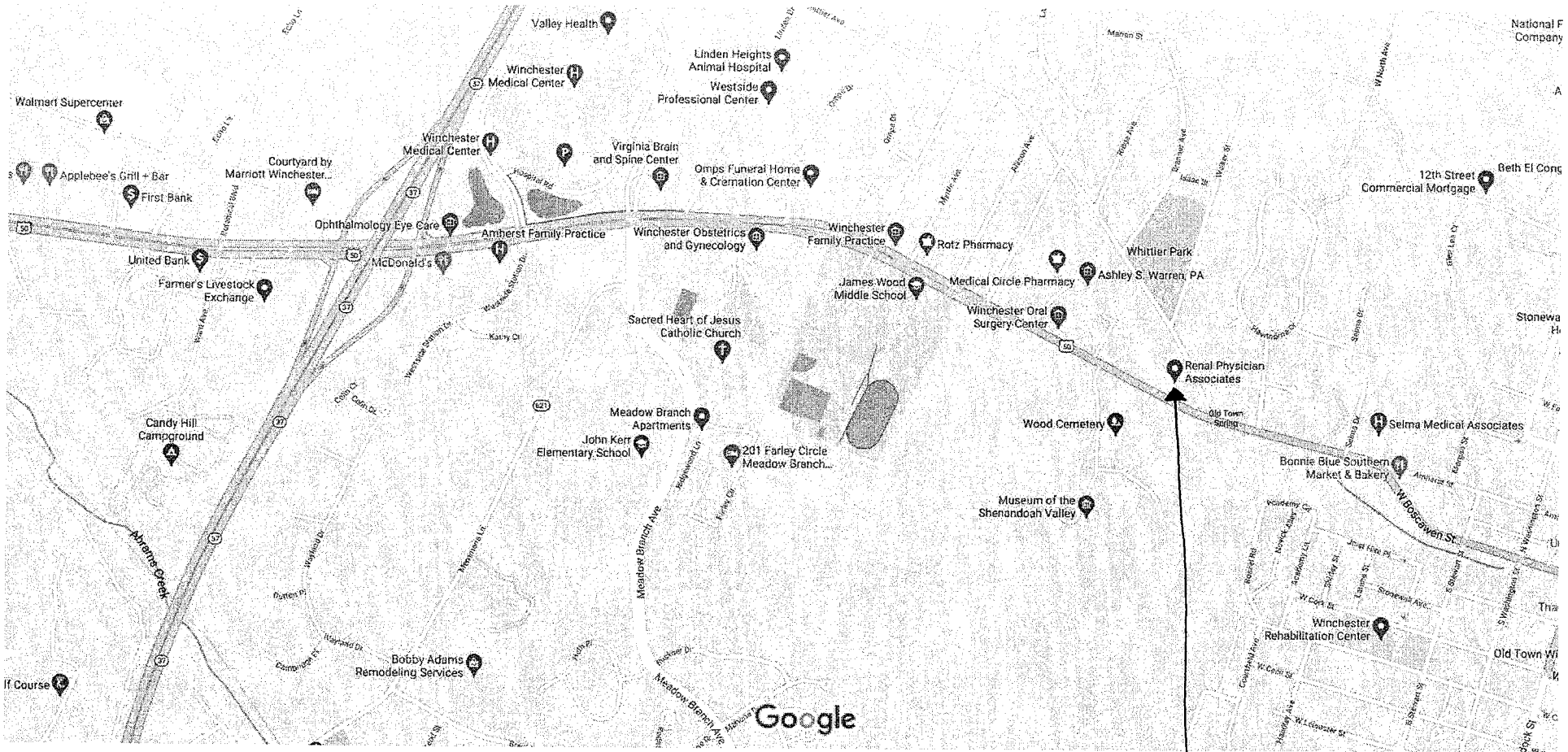
_____

_____

Date of last influenza injection: (Please list the last date of your flu shot, and where it was given.)

_____

Google Maps



RENAL PHYSICIAN ASSOCIATES
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