Nephrology Associates of Greater Houston, PLLC

11569 HWY 6 S#207 Sugarland, Tx 77498 Tel: (281) 823-8680 Fax: (281) 823-8681

www.nephrologyhouston.com

Dear Patient:

Thank you for contacting our office! Enclosed you will find paperwork for you to read and fill out. These forms need to be completed before your appointment.

Please complete the enclosed Patient Information Form and Medication List and bring all of these forms with you on your initial visit to our office.

Please carefully read the **Patient's Health History Form and complete it fully**, to the best of your knowledge, both page 1 and page 2. This is very important information needed for your consultation.

**Medical records/Laboratory tests from your referring provider must be in our office prior to your visit in order to ensure we have all needed information prior to your appointment.

Please have your:

- Completed paperwork
- Insurance cards
- Medical records/Laboratory tests you were asked to obtain if we have not already received them
- Co-pay (if required) will be collected at time of visit
- <u>If your insurance plan requires you to have a referral to see a specialist, please</u>

 <u>make sure to have your Primary Care Physician submit one to the office, before your visit.</u>

Upon arriving to our office you may be asked to collect a urine sample using the cups and wipes that are located in our waiting room bathroom.

Thank you,

Nephrology Associates of Greater Houston (Office patient letter Rev. 11/28/2020)

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PATIENT CONTACT INFORMATION SHEET

In general, the HIPPA privacy rule gives individuals the right to request a restriction on uses and disclosures of their Protected Health Information (PHI). The individual is also provided the right to request confidential communications or a communication of PHI to be made by alternative means, such as sending correspondence to the individual's office instead of their home.

I WISH TO BE CONTACTED IN THE FOLLOWING MANNER (Please check all that apply.)

Home #	Written Communication
OK to leave message with detailed information	OK to mail to my home
Leave message with call back # only	OK to mail to my work
Cell Phone #	
Work #	Fax #
OK to leave message with detailed info	
Leave message with call back number only	OK to fax to this number
OK to fax shared info to all my doctors, as needed	
E-MAIL Address:	
THIRD PARTY CONTACTS	
The primary person I wish to have access to my information	
Name Re Phone Street	elationship
Town/State/Zip CodeStreet	
The alternate person I wish to have access to my medica	
PhoneStreet	·
Town/State/Zip Code	
I have read and understand the above information and acknowledge I notify Suffolk Nephrology Consultants in writing about any changes	
PATIENT NAME	
(PRINT)DAT	E
PATIENT SIGNATURE/LEGAL REPRESENTATIVE	
(patient contact information and HIPPPA form Rev. 11/28/2020)	

PATIENT INFORMATION FORM

LAST NAME	MI	_FIRST NAME	
SOCIAL SECURITY #	SEX	DATE OF BI	RTH
STREET ADDRESS			
CITY	STATE_		_ZIP
HOME #	WORK #		CELL #
EMERGENCY CONTACT			
RELATION TO PATIENT		PHONE #	
REFERRING MD	PRI	MARY MD	
E-MAIL ADDRESS			
Black	can Indian/Alaskan Native /African American nicNon Hispanic	OtherDecl	
PRIMARY LANGUAGE(Note: Race, Ethnicity, primary la	nguage as above Required	d by CMS/Medica	re)
EMPLOYMENT:			
EMPLOYMENT STATUS (PLEAS	SE CIRCLE) FULL-TIME R	RETIRED DISABL	ED UNEMPLOYED
EMPLOYER	P	HONE #	
EMPLOYER ADDRESS			
CITY	STATE		ZIP
INSURANCE:			
PRIMARY INSURANCE	POL	ICY ID #	GROUP #
POLICY HOLDER NAME		RELATION TO P	ATIENT
POLICY HOLDER'S SS #	PC	DLICY HOLDER'S	DOB
SECONDARY INSURANCE	POLI	CY ID #	GROUP #
POLICY HOLDER NAME	F	RELATION TO PA	ΓΙΕΝΤ
POLICY HOLDER'S SS #	PC	DLICY HOLDER'S I	DOB
	ment for medical services rer		rning my illness and treatments and my dependents. I understand that I am
GUARANTOR'S SIGNATURE		DATE	

(patient information form Rev 11/28/2020)

MEDICATION LIST

DOSE:		DATE STARTED:
DOSE:	FREQUENCY:	DATE STARTED:
	1	

Nephrology Associates of Greater Houston, PLLC PATIENT'S HEALTH HISTORY FORM

□ □ Liver Disease

Anemia

<u> Page 1</u>

Name:						Date :
Date of Birth:				_		
Referring M.D.	.:					
Reason for ref	erra	al:				
Other M.D.'s c	urre	ently	seeing:			
PAST MEDICA	L H	IISTO	PRY (please check Yes	or No	o)	OTHER MEDICAL CONDITIONS OR DETAILS OF EXISTING CONDITIONS
	Yes	No		Yes	No	(please describe in the space below)
Diabetes			Stroke / CVA / TIA			
High Blood Pressure			Arthritis			
Heart disease			Cancer			
Heart Attack			Asthma / COPD			
High Cholesterol			Congestive heart failure			
Pacemaker / AICD			Peripheral vascular disease			
Kidney Disease			Blood clots			
(chronic) Kidney stones			Acute kidney failure			

Nephrology Associates of Greater Houston, PLLC PATIENT'S HEALTH HISTORY FORM

Reason for hospitalization: Reason for hospitalization: Reviewing Physician Date Reason for hospitalization: Reviewing Physician Date Reason for hospitalization: Review Reason for hospitalization: Y N Respiratory Y N Chest Pain Y N Respiratory N				-								
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(patient health history form - revised 11/28/2020)

Any Additional information