Associated Renal & Hypertension Group, PC
Parisa Hakimzadeh, DO M. Betsy Srichai, MD
P. Gina Obias, MD Kobena Dadzie, MD
7 Cedar Grove Lane, Suite 31, Somerset, NJ 08873
Tel: (732) 873-1400 Fax: (732) 960-3444 www.associatedrenal.com

PATIENT INFORMATION

Patient Name: _____ Social Security Number: _____
Date of Birth: _____ Sex: M ____ F ____ Marital Status: S___ M___ D___ W___
Street Address: _____ Apt. No: _____
City: _____ State _____ Zip Code: _____
Home phone: (____) _____ Work phone: (____)_____
Cell/mobile number: (____)_____ Email Address: _____
Guardian/Parent if patient is a minor: _____
Emergency Contact: _____ Emergency Contact Phone:(____) _____
Guarantor's Name: _____Guarantor's Social Security Number: _____
Guarantor's Date of Birth: _____ Relationship to Patient: _____
Guarantor's Address: _____ Apt. No: _____
City: _____ State _____ Zip Code: _____
Home phone:(____) _____ Cell/mobile phone:(____)_____
Employer's Name: _____ Work Phone: (____) _____
Employer's Address:_____

INSURANCE INFORMATION

Primary Insurance Company's Name: _____
Insurance Address: _____ City: _____
State _____ Zip _____ Phone Number: (____) _____
Name of Policy Holder: _____ Date of Birth: _____
Insurance ID Number: _____ Group Number: _____

Secondary Insurance Company's Name: _____
Insurance Address: _____ City: _____
State _____ Zip _____ Phone Number: (____) _____
Name of Policy Holder: _____ Date of Birth: _____
Insurance ID Number: _____ Group Number: _____

REFERRAL INFORMATION

Referring Physician: _____ Specialty: _____
City: _____ State: _____ Zip: _____

What brings you in for today's visit: _____
_____

Associated Renal & Hypertension Group, PC
Parisa Hakimzadeh, DO M. Betsy Srichai, MD
P. Gina Obias, MD Kobena Dadzie, MD

7 Cedar Grove Lane, Suite 31, Somerset, NJ 08873
Tel: (732) 873-1400 Fax: (732) 960-3444 www.associatedrenal.com

AUTHORIZATON FOR THE RELEASE OF MEDICAL RECORDS

I hereby authorize _____ to release my medical records.

Patient's Name _____

Patient's Address _____

Patient's Date of Birth _____ **Social Security Number** _____

Please forward the following records:

_____ All Records

_____ H&P

_____ Progress Notes

_____ Consultants' Letters

_____ Medication List

_____ Other: _____

_____ All Lab Results

_____ Lab Results from:

____/____/____ until ____/____/____

_____ Radiology Reports

_____ EKG/ECHO Results

SEND TO:
Associated Renal & Hypertension Group, P.C.
7 Cedar Grove Lane, Suite 31
Somerset, NJ 08873
Phone: (732) 873-1400
Fax: (732) 960-3444

Associated Renal & Hypertension Group, PC
7 Cedar Grove Lane, Suite 31, Somerset, NJ 08873
Tel: (732) 873-1400 Fax: (732) 960-3444 www.associatedrenal.com

Patient's Name: _____ DOB: _____

Local Pharmacy: _____ Phone #: _____

Mail Order Pharmacy: _____

Preferred Lab: ____ LabCorp _____ Quest _____ Other _____

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

When we call our patients with results or appointment information:
It is OK to leave a message on my voicemail. Yes _____ No ____

I authorize you to speak to those listed below regarding my medical information:

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Patient Signature: _____

I authorize ARHG to forward my medical records to the following physicians:

Primary Care Physician: _____

Other doctors involved in my care:

_____

_____

_____

_____

_____

_____

_____

Associated Renal & Hypertension Group, PC
7 Cedar Grove Lane, Suite 31, Somerset, NJ 08873
Tel: (732) 873-1400 Fax: (732) 960-3444 www.associatedrenal.com

REVIEW OF SYSTEMS – Please, mark X if you currently have or have ever had the following:

Constitutional
- ☐ Activity change
- ☐ Appetite change
- ☐ Chills
- ☐ Sweating/flushing
- ☐ Fatigue
- ☐ Fever
- ☐ Unexpected weight change

Head/Ear/Neck/Throat
- ☐ Congestion
- ☐ Dental problem
- ☐ Drooling
- ☐ Ear discharge
- ☐ Ear pain
- ☐ Facial swelling
- ☐ Hearing loss
- ☐ Mouth sores
- ☐ Nosebleeds
- ☐ Postnasal drip
- ☐ Runny nose
- ☐ Sinus pain
- ☐ Sneezing
- ☐ Sore throat
- ☐ Ringing in ears/Tinnitus
- ☐ Trouble swallowing
- ☐ Voice change

Skin
- ☐ Color change
- ☐ Pale skin color
- ☐ Rash
- ☐ Wound

Eyes
- ☐ Eye discharge
- ☐ Eye itching
- ☐ Eye pain
- ☐ Eye redness
- ☐ Light sensitivity
- ☐ Visual disturbance

Respiratory
- ☐ Sleep apnea
- ☐ Chest tightness
- ☐ Choking
- ☐ Cough
- ☐ Shortness of breath
- ☐ Stridor
- ☐ Wheezing

Cardiovascular
- ☐ Chest pain
- ☐ Leg swelling
- ☐ Heart palpitations

Gastrointestinal
- ☐ Abdominal distension
- ☐ Abdominal pain
- ☐ Rectal bleeding
- ☐ Blood in stool
- ☐ Constipation
- ☐ Diarrhea
- ☐ Nausea
- ☐ Rectal pain
- ☐ Vomiting

Endocrine
- ☐ Cold intolerance
- ☐ Heat intolerance
- ☐ Abnormal thirst
- ☐ Abnormal hunger/eating
- ☐ Urinating too much

Musculoskeletal
- ☐ Arthritis/joint pains
- ☐ Back pain
- ☐ Gait problems
- ☐ Joint swelling
- ☐ Muscle pains
- ☐ Neck pain/stiffness

Hematologic/Blood
- ☐ Enlarged lymph nodes
- ☐ Easy bruising/bleeding

Genitourinary
- ☐ Difficulty urinating
- ☐ Painful urination
- ☐ Frequent urination at night
  - ☐ How often _____
- ☐ Flank pain
- ☐ Blood in urine
- ☐ Foamy urine
- ☐ Urinary incontinence
- ☐ Penile swelling
- ☐ Scrotal swelling
- ☐ Frequent urge to urinate
- ☐ Decreased urination

Neurological
- ☐ Dizziness
- ☐ Headaches
- ☐ Light-headedness
- ☐ Numbness
- ☐ Seizures
- ☐ Speech difficulties
- ☐ Fainting
- ☐ Tremors
- ☐ Weakness

Psychiatric
- ☐ Agitation
- ☐ Behavior Problem
- ☐ Confusion
- ☐ Decreased concentration
- ☐ Depression
- ☐ Hallucinations
- ☐ Nervous/anxious
- ☐ Self-injury
- ☐ Sleep disturbance
- ☐ Suicidal thoughts

Associated Renal & Hypertension Group, PC
7 Cedar Grove Lane, Suite 31, Somerset, NJ 08873
Tel: (732) 873-1400 Fax: (732) 960-3444 www.associatedrenal.com

PAST MEDICAL HISTORY

- ☐ Kidney Disease
  - ☐ Chronic kidney disease
  - ☐ Protein in urine
  - ☐ Blood in urine
  - ☐ Kidney stones
  - ☐ Urinary tract infections
  - ☐ Urinary incontinence
- ☐ Anemia
- ☐ Blood Clots
- ☐ Cancer (type)
- ☐ Gout
- ☐ Heart Disease
  - ☐ Bypass surgery
  - ☐ Heart Attacks
  - ☐ Coronary stents
  - ☐ Congestive heart failure
  - ☐ Atrial fibrillation
- ☐ Hepatitis (A/B/C)
- ☐ High Cholesterol
- ☐ Lung)
  - ☐ COPD
  - ☐ Asthma
  - ☐ Sleep Apnea
- ☐ Gastrointestinal
  - ☐ GERD (gastric reflux)
  - ☐ Stomach/bowel ulcers
- ☐ COVID-19
- ☐ Other Medical History: _____

_____

PAST SURGICAL HISTORY

- ☐ Appendectomy
- ☐ CABG (Coronary artery bypass graft)
- ☐ Carotid Endarterectomy
- ☐ Cataract Surgery
- ☐ Gallbladder removal (cholecystectomy)
- ☐ Hernia repair
- ☐ Hip Replacement (L/R/bilateral)
- ☐ Hysterectomy
- ☐ Intestinal Surgery
- ☐ Kidney transplant
- ☐ Knee Replacement (L/R/bilateral)
- ☐ Nephrectomy
- ☐ Pacemaker/defibrillator
- ☐ Thyroidectomy
- ☐ Tonsillectomy
- ☐ Valve replacement
- ☐ Other Surgical History: _____

_____

SUBSTANCE USE

Tobacco

- ☐ Never ☐ Former
- ☐ Every Day ☐ Some Days
  - ☐ Cigarettes
  - ☐ Smokeless tobacco
  - ☐ Vaping
- ☐ How much: _____
- ☐ Quit _____

Alcohol

- ☐ No ☐ Yes ☐ Occ
  - ☐ Wine
  - ☐ Beer
  - ☐ Hard liquor
  - ☐ Other
- ☐ How much:_____
- ☐ How often:_____

Illicit Drugs

- ☐ No ☐ Yes ☐ Occ
  - ☐ "Crack" cocaine
  - ☐ Marijuana
  - ☐ Opioids
  - ☐ Other
- ☐ How much:_____
- ☐ How often:_____

SOCIAL HISTORY

Occupation History: _____

Marital Status: ☐ Divorced ☐ Domestic Partner ☐ Legally Separated ☐ Married
☐ Other ☐ Significant Other ☐ Single ☐ Widowed

Spouse/Significant Other Name: _____

Number of Children: _____

Preferred Language: _____ Ethnicity: _____

FAMILY HISTORY

Do any of your family members have any of the following medical conditions.

☐ Kidney Disease _____ ☐ High Blood Pressure _____
☐ Diabetes _____ ☐ Stroke _____
☐ Cancer _____ ☐ Gout _____
☐ Heart Disease _____ ☐ Kidney Disease _____

Mother: Alive/Deceased Age ____ Heath Conditions: _____
Father: Alive/Deceased Age ____ Health Conditions: _____

Siblings: M/F Alive/Deceased Age ____ Health Conditions: _____
Siblings: M/F Alive/Deceased Age ____ Health Conditions: _____
Siblings: M/F Alive/Deceased Age ____ Health Conditions: _____
Siblings: M/F Alive/Deceased Age ____ Health Conditions: _____
Siblings: M/F Alive/Deceased Age ____ Health Conditions: _____

Children: M/F Alive/Deceased Age ____ Health Conditions: _____
Children: M/F Alive/Deceased Age ____ Health Conditions: _____
Children: M/F Alive/Deceased Age ____ Health Conditions: _____
Children: M/F Alive/Deceased Age ____ Health Conditions: _____

CURRENT MEDICATIONS

Allergies: _____

Medication (include over the counter meds)	Dosage	Frequency
Example: Metoprolol tartrate	*25mg*	*2 times per day*

Associated Renal & Hypertension Group, PC
7 Cedar Grove Lane, Suite 31, Somerset, NJ 08873
Tel: (732) 873-1400 Fax: (732) 960-3444 www.associatedrenal.com

IMPORTANT OFFICE POLICIES

RELEASE OF MEDICAL INFORMATION
I authorize *Associated Renal & Hypertension Group, P.C.* to release the medical records concerning the above patient to any physician, hospital, or agency involved in the care of this patient.

PAYMENT POLICY
It is your responsibility to confirm your individual healthcare plan is in-network with our physicians. Co-payments are to be collected at the time services are received. We accept cash, checks, or credit card payments. All medical services provided are directly charged to the patient or responsible party. You will be responsible for any balance deemed: patient responsibility/non-payable/non-covered by your insurance and billed accordingly. Payment is expected in full upon receipt of statement or payment arrangements must be made with our billing office.

CANCELLATION POLICY
Our office requests that if an appointment needs to be cancelled that we receive notice no later than 24 hours prior to the appointment. We reserve the right to charge $50.00 for a “no show" appointment, to be collected on or before your next appointment.

REFERRAL POLICY
I understand that it is my responsibility to obtain a referral through my primary care physician's office if required by my insurance company. Failure to do so will result in charges being billed directly to myself.

I HAVE READ, UNDERSTAND, AND AGREE TO ABIDE BY THE ABOVE RELEASE OF MEDICAL INFORMATION, PAYMENT, AND OTHER OFFICE POLICIES.

Signature of Responsible Party: _____ Date: _____

ASSIGNMENT OF MEDICAL BENEFITS

I authorize my insurance carrier to assign all medical benefits, if applicable, to *Associated Renal & Hypertension Group, P.C.* I also authorize release of medical information necessary to process all medical insurance claims. I hereby authorize my insurance benefits to be paid directly to *Associated Renal & Hypertension Group, PC.* I understand and am responsible for all charges including my added costs incurred due any effort to collect for services rendered. I realize I am responsible to pay for non-covered services and I hereby authorize the release of pertinent medical information to insurance carriers.

Signature of Responsible Party: _____ Date: _____

Associated Renal & Hypertension Group, PC
7 Cedar Grove Lane, Suite 31, Somerset, NJ 08873
Tel: (732) 873-1400 Fax: (732) 960-3444 www.associatedrenal.com

DIRECTIONS TO OUR OFFICE

FROM NEWARK AIRPORT

- New Jersey Turnpike South lo Exit 9 NEW BRUNSWICK
- Bear right after toll booth
- Get into the two LEFT lanes
- Follow signs for ROUTE 18 NORTH/ NEW BRUNSWICK
- Follow directions below from ROUTE 18

FROM ROUTE 18

- Route 18 NORTH through New Brunswick
- Take exit for EASTON A VE/S. BOUND BROOK
- Follow road to traffic light, make LEFT onto LANDING LANE
- At next light, make RIGHT onto EASTON A VE, travel approx. 3.1 miles
- Stay in LEFT lane, at traffic light for CEDAR GROVE LANE, make LEFT
- Make RIGHT turn into Mandell's Plaza

FROM ROUTE 287

- Route 287 to Exit 10 NEW BRUNSWICK/EASTON A VE
- At first traffic light, make RIGHT onto CEDAR GROVE LANE
- Make RIGHT turn into Mandel l's Plaza

FROM PRINCETON

- Route 27 NORTH, make LEFT onto SOUTH MIDDLEBUSH ROAD (Route 615) Turn LEFT on Amwell Road
- Turn RIGHT onto CEDAR GROVE LANE
- Approx 3 miles, office will be on LEFT (Mandell's Plaza)

Any Questions? Please call our office for assistance.
(732) 873-1400

Associated Renal & Hypertension Group, PC
7 Cedar Grove Lane, Suite 31, Somerset, NJ 08873
Tel: (732) 873-1400 Fax: (732) 960-3444 www.associatedrenal.com

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing this form, you acknowledge that Associated Renal & Hypertension Group, PC has given you a copy of its Notice of Privacy Practices. This notice explains how your health information will be handled. HIPAA, the federal law concerning medical privacy, requires this notice.

I have received a copy of the Notice of Privacy Practices. The Associated Renal & Hypertension Group, PC has given me the opportunity to ask any questions about this notice, and all my questions have been answered.

Patient's Name Printed

Patient or Guardian Signature

Date Signed

Provider Use Only
If the patient was not able to sign due to an emergency, or did not want to sign, please document if the patient was given the notice and the reason why the patient did not sign.
Patient was given this notice: ____ Yes ____ No

Reason signature was not obtained:

Staff Signature Date