CAPITAL DISTRICT RENAL PHYSICIANS

JAMES F. HORN, M.D. • THOMAS C. SCHUMACHER, D.O. • JORGE CERDA, M.D., F.A.C.P., F.A.S.N. • PAGE V. SALENGER, M.D • M.A. MONZUR, M.D., F.A.C.P., F.A.S.N. .
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Date: ____________________________ DOB: __________________________

Name: ____ Gender: _______________

Social Security: _____________________________

Primary Language: _____________________

Preferred Method of Contact: Home Phone: ________________ Work Phone: ________________

Cell Phone: ________________

Race: _____ Hispanic or Latino _____Not Hispanic or Latino

Ethnicity: _____White _____Black or African American ____American Indian or Alaska Native

_____Asian ____Chinese _____Filipino ____Japanese _____Korean ____Samoan

____Vietnamese _____ Other

Pharmacy: ____ Phone#: __________________________

Pharmacy Address: ________________________________

Allergies: ____

Weight: ________________ Height: ___________________

Smoking Status: ______current every day smoker ______ current occasional smoker

______ never smoked _______ former smoker _________ unknown

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PH: 518-374-4207 • FAX: 518-374-4371

1 WEST AVENUE, SUITE 155
SARATOGA SPRINGS, NEW YORK 12866
PH: 518-581-0112 • FAX: 518-580-9876

PATIENT'S PERSONAL HISTORY

Patient No. ____________________

Date ____________________

Confidential Record: Information contained here will not be released except when you have authorized us to do so.

Last Name	First	Middle	Birth Date	Birth Place
Address	State	Zip	Home Phone	Business Phone

Occupation	Medicare No.	Medicaid No.	Sex M F	Marital Status	Religion

Insurance Company	Group	Insurance No.

Person to Notify____________________Relationship____________________

Address ____________________ Phone Number ____________________

Date of Last Physical Examination ____________________ Doctor ____________________

Family or Referring Physician ____________________ Address ____________________

FAMILY HISTORY

	Sex	If Living: Age	If Living: Health	If Deceased: Age at Death	If Deceased: Cause
Father					
Mother					
Brothers/Sisters* (Circle sex)					
	M F				
	M F				
	M F				
	M F				
	M F				
Husband/Wife					
Sons/Daughters* (Circle Sex)					
	M F				
	M F				
	M F				
	M F				
	M F				

Since some names may be used for either men or women, please circle sex for each Brother, Sister, Son or Daughter

Do you know of any blood relative who has or had: (Circle and give relationship)

Stroke ________ Cancer ________ High blood Pressure ________ Tuberculosis ________ Diabetes ________ Leukemia ________

Epilepsy ________ Suicide ________ Migraine ________ Asthma ________ Hay fever ________ Bleeding tendency ________

Heart Attack ________ Stomach ulcers ________ Migraine ________ Kidney disease ________ Goiter ________ Arthritis ________

Colitis ________ Nervous breakdown ________ Rheumatic heart ________ Insanity ________ Congenital heart ________

PERSONAL HABITS: (Circle)

Yes No Do you regularly smoke? Cigarettes ☐ Pipe ☐ Cigars ☐ For how many years?

Yes No Do you usually drink over 6 cups of coffee per day?

Yes No Do you regularly drink alcohol? 1 oz. per day ☐ 2 oz. per day ☐ 4 oz. per day ☐ over 6 oz. ☐

BEER: 1 bottle per day ☐ 2 bottles per day ☐ over 4 bottles per day ☐

Yes No Do you have difficulty in falling asleep?

Yes No Do you awaken early in the morning without apparent cause?

MEDICATIONS:

Are you presently taking any of the following medications? (Circle)

Yes	No	Aspirin, bufferin, anacin	Yes	No	Tranquilizers
Yes	No	Blood pressure pills	Yes	No	Weight reducing pills
Yes	No	Cortisone	Yes	No	Blood thinning pills
Yes	No	Cough medicine	Yes	No	Dilantin
Yes	No	Digitalis	Yes	No	Shots
Yes	No	Hormones	Yes	No	Water pills
Yes	No	Insulin or diabetic pills	Yes	No	Antibiotics
Yes	No	Iron or poor blood medications	Yes	No	Barbiturates
Yes	No	Laxatives	Yes	No	Birth control pills
Yes	No	Sleeping pills	Yes	No	Phenobarbital
Yes	No	Thyroid medicine	Yes	No	Other drugs not listed

Write in the names and year of any operations which you have had: ______________________________

____

____

____

Name any drugs to which you are allergic: ______________________________

____

____

____

Write in the names of any diseases you have had which required hospitalization: ______________________________

____

____

____

____

____

____

Serious Illnesses which you have had: (not requiring hospitalization) ______________________________

____

____

____

____

____

____

Serious injuries or accidents: ______________________________

____

____

____

____

____

____

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NAME:		**DOB:**
MEDICATIONS	**DOSE**	**FREQUENCY**
ALLERGIES:		

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PATIENT'S NAME: ______________________________

ADDRESS: ______________________________

HOME PHONE: ______________ WORK PHONE: ______________

DATE OF BIRTH: ______________ SOCIAL SECURITY #: ______________

EMERGENCY CONTACT: ______________________________

PRIMARY INSURANCE: ______________________________

POLICY NUMBER: ______________ GROUP NUMBER: ______________

ADDRESS: ______________________________

SECONDARY INSURANCE: ______________________________

POLICY NUMBER: ______________ GROUP NUMBER: ______________

ADDRESS: ______________________________

OTHER INSURANCE: ______________________________

ASSIGNMENT OF BENEFITS:

I hereby assign all medical and /or surgical benefits to include major medical benefits to which I am entitled, including Medicare, Medigap, private insurance, and any other health plans to Capital District Renal Physicians, P.C.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by such insurance. I hereby authorize said assignee to release all information to obtain the payment.

PATIENT SIGNATURE: ______________ DATE: ______________

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NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you, the patient, may be used and disclosed and how you can get access to this information. Please review it carefully.

USES AND DISCLOSURES OF HEALTH INFORMATION
We use health information about you for treatment, to obtain payment for treatment, and for healthcare operations purposes- for example, to evaluate the quality of care that you receive.
We may contact you to provide appointment reminders, information about treatment alternatives or other health-related benefits and services that may be of interest to you.
We may use or disclose identifiable health information about you without your authorization for several other reasons. Subject to certain requirements, we may give out health information without your authorization for public health purposes, for auditing purposes, for research studies, and for emergencies. We provide information when otherwise required by law, such as for law enforcement in specific circumstances. In any other situation, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures.
We may change our policies at any time. Before we make a significant change in our policies, we will change our notice and post the new notice in the waiting area and in each examination room. You can also request a copy of our notice at any time. For more information about our privacy practices, contact the person listed below.

INDIVIDUAL RIGHTS
In most cases, you have the right to look at or get a copy of health information about you that we use to make decisions about you. You also have the right to receive a list of instances where we have disclosed health information about you for reasons other than treatment, payment or related administrative purposes.
If you believe that information in your record is incorrect or if important information is missing, you have the right to request that we correct the existing information or add the missing information.
You may request in writing that we do not use or disclose your information for treatment, payment and administrative purposes except when specifically authorized by you, when required by law, or in emergency circumstances. We will consider your request but are not legally required to accept it.
You may also request to receive confidential communications of protected health information.

COMPLAINTS
If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact the person listed below. You also may send a written complaint to the U.S. Department of Health and Human Services.

OUR LEGAL DUTY
We are required by law to protect the privacy of your information, provide this notice about our information practices, and follow the information practices that are described in this notice. If you have any questions or complaints, please contact:
Kathryn A. Walsh, CPC, Practice Manager, 62 Hackett Boulevard, Albany, NY 12209. Phone: (518) 434-2244.

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PATIENT TREATMENT WAIVER

I (patient name) _____________________________________ am a member of (insurance company)

______________________________ who is requesting treatment from CAPITAL DISTRICT RENAL

PHYSICIANS, P.C. I am agreeing that I shall be responsible for payment in full for any charges related to this

office for services provided to me or my dependent(s). I understand that I am responsible to obtain a referral if

my insurance company requires one.(insurance company) ______________________ shall not be

responsible for any charges connected with this unauthorized visit if I do not sign the waiver and /or I fail to

obtain the required referral.

PATIENT SIGNATURE:____________________________________

DATE: ____________________

WITNESSED BY: ____

This waiver is being used to ensure the integrity and purpose of the primary care physician referral system.

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ACKNOWLEDGMENT OF RECEIPT OF NOTICE

I hereby acknowledge receipt of the Notice of Privacy Practices for Capital District Renal Physicians, PC.

Name: ____
Please Print

Signature: ______________________________ Date: _______________________

Witness: ________________________________ Date: _______________________

I, ____, designate the following person to be able to speak to a physician at CDRP, a nurse or other staff member , should it be necessary, on my behalf. I hereby give permission to CDRP through its physicians and staff to release to my designee any information about my medical condition or medical needs or the status of my account and I release CDRP, its physicians and staff, from any claim of confidentiality in connections with the release of this information.

Name of Designated Person: ____

Relationship: _________________ Phone #: ____________________(home/work)

Patient's Name: ____

Patient's Signature: ______________________ Date: _______________________

I decline to designate another person to speak with my physician or clinical staff.

Patient's Signature: ________________________ Witness: __________________________

Date: ___________________________________ Date: ________________________

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