SUFFOLK NEPHROLOGY CONSULTANTS, P.C.
Nephrology & Hypertension Specialists

2500 Nesconset Highway, Bldg. #14A
Stony Brook, NY 11790
Tel: (631) 689-7800
Fax: (631) 689-3016

M. Kirsch, M.D.
B. Moore, M.D.
M. Finger, M.D., FACP
N. Caraiani, M.D.
C. Angeles, M.D., FASN
H. Vlase, M.D.

A. Reinhart, APRN, BC
R. Bohlen, ANP- C
C. Defalco NP-C

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, both page 1 and page 2, to the best of your knowledge. This is very important information for your consultation.*

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

Please have ready 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*
- *Referral from your primary care physician –* ***you can not be seen without it!***

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

Thank you,

Suffolk Nephrology Consultants P.C.

(New office patient letter Rev. 10/10/2014

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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 Telephone:_____ _____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 Number: _____ **Fax Number:**_____

Work Number: _____ ___ OK to fax to this number
___ OK to leave message with detailed info
___ Leave message with call back number only

___ 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 in regards to my medical condition is:
Name _____ Relationship _____
Phone_____ Street _____
Town/State/Zip Code_____

The **alternate** person I wish to have access to my medical information is:
Name _____ Relationship _____
Phone_____ Street _____
Town/State/Zip Code_____

I have read and understand the above information and acknowledge that these directions are considered in effect until I notify Suffolk Nephrology Consultants in writing about any changes.

PATIENT NAME
(PRINT)_____DATE_____

PATIENT SIGNATURE/LEGAL REPRESENTATIVE_____

PATIENT INFORMATION FORM

LAST NAME_____MI_____FIRST NAME_____

SOCIAL SECURITY #_____SEX_____DATE OF BIRTH_____

STREET ADDRESS_____

CITY_____STATE_____ZIP_____

HOME #_____WORK #_____CELL #_____

EMERGENCY CONTACT_____

RELATION TO PATIENT_____PHONE #_____

REFERRING MD_____PRIMARY MD_____

E-MAIL ADDRESS_____

Race ____American Indian/Alaskan Native ____Asian/Pacific Islander ____Caucasian
____Black/African American ___Other ___Decline to Answer
Ethnicity ____Hispanic ____Non Hispanic ____Decline to Answer

PRIMARY LANGUAGE_____
(Note: Race, Ethnicity, primary language as above Required by CMS/Medicare)

EMPLOYMENT:

EMPLOYMENT STATUS (PLEASE CIRCLE) FULL-TIME RETIRED DISABLED UNEMPLOYED

EMPLOYER_____PHONE #_____

EMPLOYER ADDRESS_____

CITY_____STATE_____ZIP_____

INSURANCE:

PRIMARY INSURANCE_____POLICY ID # _____GROUP #_____

POLICY HOLDER NAME_____ RELATION TO PATIENT_____

POLICY HOLDER'S SS #_____POLICY HOLDER'S DOB_____

SECONDARY INSURANCE_____POLICY ID #_____GROUP #_____

POLICY HOLDER NAME_____RELATION TO PATIENT_____

POLICY HOLDER'S SS #_____POLICY HOLDER'S DOB_____

I hereby authorize my provider to furnish information to insurance carriers concerning my illness and treatments and hereby assign to the physician all payment for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance.

GUARANTOR'S SIGNATURE_____DATE_____

(patient information form Rev 04/25/16)

MEDICATION LIST

Patient's Name:_____ Date:_____

PHARMACY_____ PHONE _____

MEDICATION:	DOSE:	FREQUENCY:	DATE STARTED:

ALLERGIES / DRUG REACTIONS:

(medication list and allergies Rev. 4/27/16)

SUFFOLK NEPHROLOGY CONSULTANTS, P.C.

PATIENT'S HEALTH HISTORY FORM

Dear Patient please fill in both page 1, and page 2 (please see over) **Page 1**

Name:_____ **Date :** _____

Date of Birth: _____

Referring M.D.: _____

_____

Reason for referral: _____

_____

_____

Other M.D.'s currently seeing: _____

_____

_____

_____

PAST MEDICAL HISTORY (please check Yes or No)

OTHER MEDICAL CONDITIONS OR DETAILS OF EXISTING CONDITIONS
(please describe in the space below)

	Yes	No		Yes	No	
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 (chronic)	☐	☐	Blood clots	☐	☐	_____
Kidney stones	☐	☐	Acute kidney failure	☐	☐	_____
Anemia	☐	☐	Liver Disease	☐	☐	_____

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PATIENT'S HEALTH HISTORY FORM

PAST SURGICAL HISTORY (please list below important surgeries you had in the past):

_____

_____

_____

_____

_____

Hospitalization (Past Year) Yes ___ No ___ If Yes, name of Hospital: _____

Reason for hospitalization: _____

_____

REVIEW OF SYSTEMS

(please mark YES – Y, if you have any of following symptoms, or NO -N if you do not have symptoms)

Constitutional	**Y**	**N**	**HEENT**	**Y**	**N**	**Respiratory**	**Y**	**N**	**Cardiovascular**	**Y**	**N**
Weight Loss			Decreased vision			Shortness of breath			Chest Pain		
Weight Gain			Blurry vision			Cough			Palpitations		
Fever			Diabetic retina disease			Wheezing			Edema / leg swelling		
Chills			Bleeding behind the eye			Difficulty breathing			Fainting episodes		
Excessive tiredness			Other			Lung disease			Leaky heart valves		
Gastrointestinal	**Y**	**N**	**Genitourinary**	**Y**	**N**	**Musculoskeletal**	**Y**	**N**	**Skin**	**Y**	**N**
Nausea			Burning on urination			Joint aches			Itchy skin		
Vomiting			Blood in urine			Joint Swelling			Rashes on body		
Poor appetite			Frequent urination			Muscle aches			Dry skin		
Diarrhea			Urinary tract infections			Muscle swelling					
Blood in stool			Kidney stones in past			Pain killer use			**Other symptoms (describe)**		
Neurologic	**Y**	**N**	**Endocrine**	**Y**	**N**	**Hematologic**	**Y**	**N**			
Confusion			Excess thirst			Easy bruising					
Lightheadedness			Cold Intolerance			Blood clots					
Severe headaches			Heat Intolerance			Bleeding disorder					
Numbness in feet			Large amount urine								

SOCIAL HISTORY: Marital status_____ Occupation_____

Non-smoker (never smoked) _____ Ex-smoker (year quit)_____ Current smoker _____ cigarettes / day_____

Alcohol consumption, occasional _____, frequent_____, never _____

FAMILY HISTORY: (please list any known medical problems)

Father:_____

Mother: _____

Siblings: _____

Your Children: _____

ADDITIONAL INFORMATION: (Use this space to provide any additional information important to your health)

_____ _____

Signature of Reviewing Physician Date Signature of Patient Date

_____

Signature of Nurse Practitioner Date

(patient health history form - revised 2/1/2011)

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NO SHOW CANCELLATION POLICY

Suffolk Nephrology Consultants is committed to meet all of our patient's health care needs.

Effective October 8, 2008, please be advised of the following new policy:

All appointments must be cancelled by 10:00 AM the day before your appointment (or by 10:00 AM on the Friday before a Monday appointment) to avoid incurring a no-show cancellation fee being charged to you.

PLEASE NOTE: *Insurances* ***do not*** *cover a no-show cancellation fee, so the patient will be responsible for payment.*

A NO SHOW CANCELLATION fee of $25 will be charged to you if an appointment either is missed or not cancelled as instructed above.

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