North Jersey Nephrology
ASSOCIATES P.A.

Patient Name: _____

Appointment Date & Time: _____

Location

- ☐ 246 Hamburg Turnpike, Suite#207, Wayne, NJ 07470
- ☐ 50 Mt. Prospect Ave. Suite # 101, Clifton, NJ 07013
- ☐ 1031 McBride Ave, Suite# D209, Woodland Park, NJ 07424
- ☐ 230 West Parkway, Suite # 10, Pompton Plains, NJ 07444
- ☐ 764 Main St. Suite 3C, Paterson, NJ 07503

PHONE # - 973-653-3366

FAX # - 973-653-3365

Clinician

- ☐ Manuel J. Moquete, M.D.
- ☐ Nazifa Banu, M.D.
- ☐ Pat F. Audia, M.D .
- ☐ Chandra Chandran, M.D.
- ☐ Vipul Bhalara, M.D.
- ☐ Meghna Desai, M.D.
- ☐ Marissa Maddalena, PA-C
- ☐ Harjinder S. Saini, M.D.
- ☐ Vincent Graziano, M.D.
- ☐ Sanjay R. Shah, M.D.
- ☐ Alicia Notkin, M.D.
- ☐ George Bonifant, M.D.
- ☐ Lauren A. Letizia, APN

North Jersey Nephrology
ASSOCIATES P.A.

Welcome to our office

This letter is to provide our patients with a list of all the materials needed on the day of the appointment, so patients can be seen efficiently.

1. Please bring in all bottles of medications you are currently taking.
2. Most recent blood work results and/or results of any radiology test, pertaining to the kidneys.
3. Insurance cards
4. The new patient packet which is enclosed- completed and signed.
5. If your insurance requires a referral please make sure you obtain it from your primary doctor prior to your appointment.

We strive to render excellent medical care to you and the rest of our patients. When an appointment is scheduled, that time has been set aside for you and when it is missed, that time cannot be used to treat another sick patient. We request that you please give our office a 24 hour notice in the event that you need to reschedule your appointment. It also makes it possible to reschedule your appointment to a more convenient time.

Please call our office if you have any questions or concerns.

Thank you,

North Jersey Nephrology Associates

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ASSOCIATES P.A.

Bienvenido a nuestra oficina,

Para que usted pueda ser visto de manera efectiva por nuestro medico por favor traiga los siguientes articulos con usted para su vicita:

1. Por favor de traer su medicamentos
2. Analisis de sangre y/o los resultados de la radiologia en relacion con los rinones
3. Tarjetas de seguro
4. Las formas que le enviamos, llenado y firmado
5. Si usted necesita un referido con su seguro, por favor obtener uno de su medico primario antes de la cita.

Por favor considere el horario en que usted escogio para hacer su cita. Estas cistas estan reservadas esclusivamente para usted. Una cita perdida/cancelada o cambiada sin un previo aviso de 24 horas nos deja con un tiempo de servicio que podria haber sido utilizado para otro paciente.

Llame a nuestra oficina con cualquier pregunta.

Gracias

North Jersey Nephrology Associates

North Jersey Nephrology ASSOCIATES P.A.

Patient Registration Form

Referred by:_____

Name:_____ Date of Birth:_____
Address:_____
City/ State: _____ Zip:_____
Home Phone: _____ Cell Phone: _____

Gender: ___Male ___Female

Ethnicity: __Hispanic/ Latino __Not Hispanic/ Latino

Marital Status: __Single __Married __Widowed __Divorced

Race: __American Indian or Alaskan Native, __Black or African American, __Native Hawaiian or __Other Pacific Islander, __White, Other: _____

Employer Name: _____ Phone Number: _____
Employer Address:_____ City/State: _____

Insurance Information

Primary Insurance:_____
ID No: _____ Group No: _____
Insured's Name: _____ Relation to Insured: __Self __Spouse __ Other
Subscriber's Name: _____ Subscriber's Date of Birth: _____

Secondary Insurance: _____
ID No: _____ Group No: _____
Insured's Name: _____ Relation to Insured: __Self __Spouse __ Other
Subscriber's Name: _____ Subscriber's Date of Birth: _____

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original.
I hereby authorize North Jersey Nephrology Associates, to apply for benefits on my behalf for covered services rendered by my family physician or by his/ her order. I request that payment from my insurance company be made directly to North Jersey Nephrology Associates (or to the party who accepts assignment),
I certify that the information I have reported with regard to my insurance coverage is correct.
I agree and accept the terms of the North Jersey Nephrology Associates Financial Policy.
I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or my insurance company at any time in writing,

Date: _____ Signature:
_____

North Jersey Nephrology ASSOCIATES P.A.

PATIENT NAME:_____ **DOB:**_____

Family History: PLEASE CIRCLE ANSWERS PERTAINING TO EACH DISEASE AND FILL IN TYPE UNDERNEATH

DISEASE:					
KIDNEY	NONE	FATHER	MOTHER	SIBLING	CHILD
***TYPE OF KIDNEY DISEASE:**					
DIABETES	NONE	FATHER	MOTHER	SIBLING	CHILD
***TYPE OF DIABETES:**					
HIGH BLOOD PRESSURE	NONE	FATHER	MOTHER	SIBLING	CHILD
ISCHEMIC HEART DISEASE	NONE	FATHER	MOTHER	SIBLING	CHILD
***TYPE OF HEART DISEASE:**					
CANCER	NONE	FATHER	MOTHER	SIBLING	CHILD
***TYPE OF CANCER:**					
STROKE	NONE	FATHER	MOTHER	SIBLING	CHILD
***TYPE OF STROKE**:					
GOUT	NONE	FATHER	MOTHER	SIBLING	CHILD
***TYPE OF GOUT:**					
AUTOSOMAL DOMINANT POLYCYSTIC KIDNEY DISEASE:	NONE	FATHER	MOTHER	SIBLING	CHILD
***TYPE OF ADKP:**					
DEMENTIA	NONE	FATHER	MOTHE	SIBLING	CHILD
***TYPE OF DEMENTIA:**					

Status:

FATHER:	LIVING	DECEASED: AGE:	CAUSE:	UNKNOWN
MOTHER:	LIVING	DECEASED: AGE:	CAUSE:	UNKNOWN

Tobacco Use: PLEASE CIRCLE ONE

CURRENT USER	FORMER USER	NEVER USED	UNKNOWN

TYPE: PLEASE CIRCLE

CIGARETTES	PIPES	CIGARS	CHEWING TOBACCO	SNUFF

FORMER USER: YEAR STARTED:_____ YEAR ENDED:_____

IMMUNIZATION:

WHEN WAS THE LAST INFLUENZA VACCINE ADMINISTERED? DATE: _____WHERE?_____

WHEN WAS THE LAST PNEUMONNIA VACCINE ADMINSTERED? DATE:_____WHERE?_____

North Jersey Nephrology ASSOCIATES P.A.

NOMBRE:_____ **FECHA DE NACIMIENTO:**_____

HISTORIA FAMILIAR: POR FAVOR CIRCULE PARA CADE ENFERMEDAD Y LLENE TIPO

ENFERMEDAD:	NINGUNO	PADRE	MADRE	HERMANOS	HIJOS
RENAL	NINGUNO	PADRE	MADRE	HERMANOS	HIJOS
***TIPO DE ENFERMEDAD RENAL:**					
DIABETES	NINGUNO	PADRE	MADRE	HERMANOS	HIJOS
***TIPO DE DIABETE:**					
ALTA PRESION	NINGUNO	PADRE	MADRE	HERMANOS	HIJOS
***TIPO DE ALTA PRESION:**					
ISQUEMICA DEL CORAZON					
***TIPO ISQUEMICA DEL CORAZON:**					
CANCER	NINGUNO	PADRE	MADRE	HERMANOS	HIJOS
***TIPO DE CANCER:**					
DERRAME CEREBRAL	NINGUNO	PADRE	MADRE	HERMANOS	HIJOS
***TIPO DE DERRAME CEREBRAL:**					
GOTA	NINGUNO	PADRE	MADRE	HERMANOS	HIJOS
***TIPO DE GOTA:**					
ENFERMEDAD RENAL POLIQUISTICA AUTOSOMICA DOMINANTE	NINGUNO	PADRE	MADRE	HERMANOS	HIJOS
***TIPO DE ENFERMEDAD RENAL POLIQUISTICA UTOSOMICA DOMINANTE:**					
DEMENCIA					
***TIPO DE DEMENCIA:**					

ESTADO:

PADRE:	VIVIR	FALLECIDO: EDAD: CAUSA:	DESCONOCIDO
MADRE:	VIVIR	FALLECIDO: EDAD: CAUSA:	DESCONOCIDO

USO DE TABACO: POR FAVOR CIRCULE UNA

USUARIO ACTUAL	USARIO ANTERIOR	NUNCA USADO	DESCONOCIDO

TIPO: POR FAVOR CIRCULE UNA

CIGARILLOS	TUBOS PUROS	TABACO	TABACO DE MASCAR	TABACO EN POLVO

USUARIO ANTERIOR: ANO DE INICIO:_____ ANO TERMINADO:_____

VACUNAS:

Cuando se administró la vacuna contra la influenza? _____ Donde? _____

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Patient Medication List

Patient Name: _____D.O.B:_____

Allergies: _____

PHARMACY NAME & PHONE#:_____

Name of Medication	Dose & Frequency	Reason taking

Patient Record of Disclosure

I _____ give permission to the physicians and their staff at
(Please print patient name)

North Jersey Nephrology Associates to leave messages regarding my healthcare in the following manner when I am not available:

(Please check all that apply)

_____ I would prefer to be contacted at: _____ Home # _____

_____Work # _____

_____Cell # _____

_____Other # _____

_____ May ONLY leave information with me. **(If you check here, no other choices should be checked)**

_____ May leave appointment reminders on my answering machine/voice mail.

_____ May leave appointment reminders with my family.***PLEASE NOTE NAME, PHONE # & RELATIONSHIP BELOW**

_____ May leave lab results on my answering machine/ voice mail.

_____ May leave lab results with my family.***PLEASE NOTE NAME, PHONE # & RELATIONSHIP BELOW**

_____ May leave general questions/information on my answering machine/voice mail.

_____ May leave general questions/information with my family. * **PLEASE LIST NAME, PHONE # & RELATIONSHIP BELOW**

***if you choose to give our office authorization to speak to any family member(s), please list name of individual(s) we may give information to**:

Name:_____ Relationship:_____

Phone #:_____

_____ _____

Patient's Signature **DATE**

North Jersey Nephrology
ASSOCIATES P.A.

Informed Consent

Patient Name (please print): _____

My signature below indicates that I have been provided, upon my request, with a copy of the following information:

Included in the packet:
Financial & Office Policies
Transfer of Care
Upon my request:
Client Rights
Important Information
Notice of Privacy Practices

Assignment of Benefits

I hereby authorize direct payment to North Jersey Nephrology, PA of any medical benefits otherwise payable to me for services provided by a provider affiliated with North Jersey Nephrology, PA.

Records Release

I hereby authorize North Jersey Nephrology, PA to release my records to my insurance company and/or primary care physician for the purpose pf processing my insurance claims. This authorization shall remain in effect as long as charges are being submitted for insurance claim processing, or as long as dictated by payer.

Financial Responsibility

I take full responsibility for all co-pays, balances not covered by my individual medical insurance provider and any other fees that pertain to the status of my account.

These forms have been explained to me and I have been given the opportunity to ask questions about them. By signing this form, I am consenting to treatment for myself; or as a personal representative, to the treatment of the patient.

X_____ _____

Signature of Patient/ Client or Personal Representative Date

*If signed by a personal representative, relationship to patient: _____