Nephrology Associates
Diseases of the Kidneys, Dialysis,
Hypertension, Renal Transplantation

Eric L Cheung, M.D.
S. Federico Calaf, M.D.
Sandra Barrow, M.D.
Rangashree Varadarajan, M.D.
Lorigail T. Echipare, D.O.

NEW PATIENT INFORMATION PACKET

Your appointment is at the following location:

☐ 2301 Circadian Way, Ste. A ▪ Santa Rosa, CA 95407
Phone: 707-526-2027

Instructions for your first appointment (if checked):
Please use ink to fill out these forms, in full, prior to your appointment.

☐ **Bring this packet with you, with all forms completed.**

☐ **Mail this packet back to our office in the enclosed envelope, with all forms completed.**

☐ **We are requesting additional studies to be ordered by your referring provider.**
All requested studies MUST be completed by _____ to avoid being cancelled.

☐ **Bring your current insurance card and a photo ID and** update any changes as they occur.
If you are scheduled for a Video consult, please include a copy of your insurance cards and photo ID.

☐ **Bring all prescription bottles and over the counter medications** you are currently taking. **OR bring an updated list of all your current medications**, including dosage and frequency.

☐ **Arrive _____ minutes early to register.** Failure to do so may result in a delay of your appointment.

☐ **We will call you to confirm your appointment.** You MUST confirm your appointment. 48 hours prior to your visit or your appointment will be cancelled.

☐ **Cancellation and No-Show policy**.

Thank you for your cooperation. We look forward to meeting you and assisting you in any way we can.

NEPHROLOGY ASSOCIATES

2301 Circadian Way, Ste. A ▪ Santa Rosa, CA 95407 ▪ Tel 707-526-2027 ▪ Fax 707-526-2096

Patient Information Form		Today's Date:
First Name:	Last Name:	Date of Birth:
Street:	City:	State & Zip:
Sex: Male Female	Martial Status: Single/ Married/ Div/ Widow (er)	Social Security #
Primary Language:	Race/Ethnicity:	Employer:
E-mail:		
Best Way to Contact: Phone:	Home:	Cell: Work:
If you are not available may we leave a message? Yes / No		
In Case of Emergency, whom should we contact?		
Relationship to Patient:		Best Contact info:
Who is your Primary Physician?		
Who is your referring Physician?		

Insurance Information

Primary Insurance:		Secondary Insurance:	
Subscriber's Name:	DOB:	Subscriber's Name:	DOB:
Subscriber's SSN#:		Subscriber's SSN #:	
ID/Policy#	Group#	ID/Policy#	Group#
Effective Date:	Relationship to Patient:	Effective Date:	Relationship to Patient:
Is the subscriber employed?	Full or part-time?	Employer:	Work Phone:

Authorization

I hereby authorize the release of Medical Information to Nephrology Associates for the purpose of providing medical care to myself. This authorization is limited as follows:

Any records requested □

Any Records Except those relating to: Mental Health □ Drug & Alcohol □ HIV/ AIDS □

This authorization expires:	In 12 months	Never
Patient's Name:	Signature & Date:	

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Authorization to Bill Medicare on your Behalf

Name of beneficiary (Patient).	HIC (Medicare) Number:

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Drs. Eric L. Cheung, Federico Calaf, Sandra Barrow, Rangashree Varadarajan, Lorigail T. Echipare of Nephrology Associates for any services furnished to me by Nephrology Associates.
I authorize any holder of medical information about me to release to the Health Care Financing Administration and it's agents, any information needed to determine these benefits payable to related services.

I understand my signature requests that payment be made, and authorize release of medical information necessary to pay the claim. If other health insurance coverage is indicated in Item 9 of the HCFA-1500 claim form or elsewhere on the other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, Nephrology Associates agrees to accept the charge determination of the Medicare Carrier as the full charge, and the patient is responsible only for the deductible, coinsurance and non-covered services. Coinsurance and deductible are based upon the full charge determination of the Medicare carrier.

Signature Date

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Cancellation and No-Show Policy

Please be courteous and call Nephrology Associates at least 24 hours in advance if you are unable to attend your scheduled appointment. This time will be allocated to someone who is in urgent need of treatment. Available appointments are in high demand and your early cancellation will give another person the possibility to have access to timely medical care.

Patients who fail to show for their scheduled appointment, did not notify the office of cancelation or make any changes less than 24 hours in advance of their scheduled appointment time, shall be subject to a "No Show/Cancellation" fee of $50.00.

My signature below indicates that I have read, understand, and agree to the cancellation and No-Show policies, as described above.

Signature_ _____ Date: _____

Please print your full name: _____

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ASSIGNMENT OF BENEFITS AND TREATMENT

I hereby assign all medical and/or surgical benefits to which I am entitled including Medicare and other government sponsored programs, private insurance, and other health plans to DRS. ERIC L. CHEUNG, FEDERICO CALAF, SANDRA BARROW AND RANGASHREE VARADARAJAN, LORIGAIL T. ECHIPARE

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 said insurance. I hereby authorize said assignee to release all information necessary to secure payment.

It is our policy to submit claims for services to health plans; however, if your health plan does not provide benefits, you will be personally billed.

If you have specific questions about your health coverage, please contact your health plan directly.

To confirm your understanding, please sign where indicated below.

I understand that my health plan may not provide benefits for today's services. In the event that benefit coverage is not available, I will be responsible for payment.

Signed:_____ Date: _____

Please print your full name: _____

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Medical History

This is a confidential part of your medical history and will be kept as a permanent part of your chart. Release of any information contained in all pages of this form requires your written authorization as mandated by Health Privacy and Portability regulations (HIPAA)

Name	Age:	Date of birth:
Today's Date:	Height:	Weight:
Your Primary Care Provider:		
Your Referring Physician:		
Reason for Today's appointment:		

Past Medical History

Please, list all your medical problems

Diagnosis	Date	Doctor

Past Surgical History

Please list all surgeries you have had in the past

Type	Date	Surgeon	Complications if any

Medications

Please complete the attached medication form, including any over the counter medications such as NSAIDS, herbal medications, alternative medical therapies or natural remedies

Name of Medications	Dosage	Name of Medications	Dosage

Patient's Preferred Pharmacy:

Nephrology Associates

Family History

Relative	Age	Health	Age at death	Cause of Death
Father				
Mother				
Siblings				
Children				

Have any of your immediate relatives ever had: Check if Yes - Who?

□ Cancer □ Heart Disease □ Sickle Cell □ Congenital deformities □ Diabetes □ Stroke

□ Kidney Disease □ Dialysis □ High Blood Pressure □ Polycystic Kidney Disease □ Other

Social History

Please check any that apply

Present Occupation:		If Retired, previous occupation:		
□Married □Single □Widowed □Divorced	□ I Live Alone:	□ I live with someone who can care for me	□ I live alone but have friends or family that can care for me	□ I live with someone who is unable to care for me

Habits

SMOKING	□I do not smoke and have never smoked	
	□Quit smoking; When? How many years?	Packs per day:
	□I Currently Smoke How many years?	Packs per day:
ALCOHOL:	Do you consume Alcoholic beverages? Type?	#per week:
	Have you ever had a drinking problem?	
	Do you use Recreational Drugs Now? Have you ever used recreational drugs?	

Allergies or High Risk Medications

□Penicillin □Sulfa □Aspirin □Iodine □Shellfish □Latex □Tape □ACE Inhibitors

Please list ANY Substances to which you are allergic and note the type of reaction:

Do you wish to tell us anything else we have not addressed?

Review of Systems - Please check YES if you currently have, or have ever had the following:					
Problem	**YES**	**NO**	**Problem**	**YES**	**NO**
Recent, Unintentional Weight Changes			Stomach Ulcers or Pains		
			Jaundice		
Spots before Eyes, Diabetic Eye Disease			Hiatal Hernia		
			Reflux or heart burns		
Blurred, double vision or Glaucoma			Intestinal Bleeding		
			Nausea or Vomiting		
Poor hearing or ringing in ears			Diverticulitis		
Mouth Sores, Ulcers or Thrush			Hemorrhoids		
Difficult Swallowing			Bloody or black tarry stools		
Nosebleeds			Hepatitis		
Frequent or severe headaches			History of Internal Bleeding		
Sinus Trouble or Hoarseness			Gallbladder problems		
Coughing up blood			Colitis		
Pleurisy			Constipation		
Bronchitis or Emphysema			Diarrhea		
Asthma or Wheezing			Lose Urine on coughing or sneezing		
Swelling in your legs			Kidney Stones		
Shortness of breath			Difficulty starting Urine		
Chest pains or Angina			Blood in Urine		
Dizziness or Fainting spells			Trouble emptying Bladder		
Persistent Cough			Dribbling at end of Urination		
Heart Attacks			Back Pains		
Wake at Night Short of breath			Fevers or Night Sweats		
Leg Cramps on walking			Enlarged glands or lymph nodes		
Irregular heartbeat, palpitations			Easy bruising		
Heart Failure			Skin Problems		
Previous Blood transfusion			AIDS or HIV positive		
Poor Appetite			Psoriasis		
Snoring			Skin Problems		
Anemia			Changes in Hair		
Blood Clots in Legs or Lungs			Arthritis		
Epilepsy or seizures			Joint Swelling		
Tingling in feet & hands			Muscle Aches		
Stroke			Joint Pains		
Mental Illness			Gout or Lupus		
Depression			Diabetes of thyroid disease		
Tremors or Falls			OTHER:		
Patient's Name:			Signature & Date:		

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Directions to Nephrology Associates

2301 Circadian Way, Ste. A, Santa Rosa, CA 95407

1.Start out going North or South on US-101 towards Santa Rosa.

2.Merge onto CA-12 West towards Sebastopol.

3.Take the Stony Point Rd Exit, EXIT 5

4.Turn LEFT onto Stony Point RD-0.35miles

5.Turn RIGHT on Sebastopol RD-0.6miles

6.Turn LEFT onto Corporate Center Parkway -0.3miles

7.Turn RIGHT on Circadian Way.
Make an immediate right into the parking lot.