Bergen Hypertension & Renal Associates

Patient's Name (Please print): _____
E-Mail Address (Please print): _____

I authorize Bergen Hypertension & Renal Associates to release any laboratory or test results & discuss my medical condition with: (please list names below)

Myself: _____
Spouse: _____
Parent: _____
Other: _____
Doctor: _____

May we leave a phone message regarding confidential health information such as lab work or test results? Yes ☐ No ☐

Please indicate which phone numbers we can use to leave confidential health information.

Primary phone _____ / _____ / _____ (Home/Cell/Work)
Secondary phone _____ / _____ / _____ (Home/Cell/Work)
Tertiary phone _____ / _____ / _____ (Home/Cell/Work)
Email _____

Signature _____
Witness _____
Date _____

Bergen Hypertension & Renal Associates

SUMMARY OF PRIVACY PRACTICES

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

We understand that your medical information is personal to you, and we are committed to protecting the information about you. As our patient, we create medical records about your health, our care for you, and the services and items we provide to you as our patient. By law, we are required to make sure that your protected health information is kept private.

How will we use or disclose your information? Here are a few examples.

- For medical treatment.
- To obtain payment for our services.
- To run our practice more efficiently & ensure all our patients receive quality care.
- To avert a serious threat to health or safety
- For appointment and patient recall reminders

If you believe your privacy rights have been violated, you may file a complaint with the Practice. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

You have certain rights regarding the information we maintain about you. These rights include:

- The right to inspect and copy
- The right to amend
- The right to an accounting of disclosures
- The right to request restrictions

For more information about these rights please do not hesitate to ask us.

I _____, have been given the opportunity to read and or receive Bergen Hypertension's notice of privacy practices.

_____ _____

Signature of patient Date

Bergen Hypertension & Renal Associates
MEDICATION LOG
must be completed prior to appointment

Patient Name: _____ Date of Birth: _____

Home Phone: _____ Work Phone: _____

Pharmacy Name: _____ Pharmacy Phone: _____

Allergies to medications	***Other allergies***

Medication	Dose	Frequency

BERGEN HYPERTENSION & RENAL ASSOCIATES
NEW PATIENT INFORMATION FORM
(PLEASE PRINT CLEARLY)

NAME: _____ DATE: _____

ADDRESS: _____ SEX: ____ SS#_____

CITY: _____ STATE: _____ ZIP: _____ DOB: _____

OCCUPATION: _____ EMPLOYER: _____

HOME PHONE: _____ WORKPHONE: _____

CELL PHONE: _____ EMAIL: _____

WHO IS RESPONSIBLE FOR THE BILL: _____

RELATIONSHIP: _____ DATE OF BIRTH: _____

MARITAL STATUS: M☐ S☐ W☐ D☐ SPOUSE: _____

PRIMARY PHRAMACY NAME _____ PHONE: _____

NAME OF INSURANCE CARRIER: _____

INSURANCE CARRIER ID#: _____

SUBSCRIBER'S NAME: _____

SUBSCRIBER'S DOB: _____

SECONDARY INSURANCE (IF APPLICABLE): _____

SECONDARY ID #: _____

REFERRING DOCTOR: _____ PHONE: _____

REFERRING DOCTOR'S SPECIALTY: _____

FAMILY DOCTOR: _____ PHONE: _____

FAMILY HISTORY: (Please check all that apply)

Chronic Kidney Disease:	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Daughter	☐ Son
Hypertension:	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Daughter	☐ Son
Coronary Artery Disease:	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Daughter	☐ Son
Cancer:	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Daughter	☐ Son
Diabetes:	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Daughter	☐ Son

MEDICAL HISTORY: _____

_____

SURGICAL HISTORY: _____

_____

SOCIAL HISTORY:

☐ Cigarette Smoking

☐ Never smoked

☐ Quit/former smoker

☐ Smokes less than a pack daily

☐ Smokes Daily

Alcohol Intake:

☐ None

☐ Less than 1 drink per day

☐ 1 to 2 Drinks per day

☐ 3 or more drinks per day

I HEREBY AUTHORIZE BERGEN HYPERTENSION & RENAL ASSOCIATES TO RELEASE TO MY INSURANCE CARRIER ANY MEDICAL INFORMATION NECESSARY FOR THE COMPLETION OF MY MEDICAL CLAIM. I UNDERSTAND THAT THIS MAY INCLUDE COPIES OF MY MEDICAL RECORDS OR LAB RESULTS.

SIGNATURE: _____

DATE: _____