North Georgia Nephrology Consultants
PATIENT INFORMATION

PATIENT NAME:_____

ADDRESS:_____

CITY:_____**STATE:**_____**ZIP CODE**_____

HOME PHONE:_____**WORK PHONE:**_____

MALE/FEMALE **BIRTH DATE:**_____

SOCIAL SECURITY NUMBER:_____

EMERGENCY CONTACT:_____**RELATIONSHIP:**_____

EMAIL ADDRESS:_____

PRIMARY PHYSICIAN:_____**PHONE:**_____

(CIRCLE ONE) ASIAN BLACK HISPANIC WHITE OTHER

(CIRCLE ONE) DIVORCED MARRIED SINGLE WIDOWED SEPARATED

EMPLOYER NAME:_____**OCCUPATION**_____

PREFERRED PHARMACY:_____**PHONE:**_____

HOW DID YOU HEAR ABOUT YOUR PRACTICE: (CIRCLE ONE)
PHYSICIAN FRIEND RELATIVE NEWSPAPER TELEPHONE BOOK OTHER
NAME OF PERSON WHO REFERRED YOU:_____

PERSON RESPONSIBLE FOR PAYMENT:
If person responsible for the bill is the same as the patient. You do not need to complete.

NAME:_____

ADDRESS:_____

CITY:_____**STATE:**_____**ZIP CODE**_____

HOME PHONE:_____ **WORK PHONE:**_____

EMPLOYER NAME:_____**OCCUPATION:**_____

INSURANCE INFORMATION

******IF WE HAVE OBTAINED A COPY OF YOUR INSURANCE CARD YOU DO NOT NEED TO FILL THIS SECTION BUT YOU STILL NEED TO SIGN IT.**************

PRIMARY INSURANCE

NAME OF INSURANCE_____**MEDICAID/MEDICARE/CHAMPUS**

GROUP #:_____**POLICY #:**_____**EFFECTIVE DATE:**_____

RELATIONSHIP TO PATIENT: SELF HUSBAND WIFE DEPENDENT

COPAY AMOUNT:_____**DEDUCTIBLE AMOUNT:**_____

POLICY HOLDER NAME:_____

POLICY HOLDER ADDRESS:_____

CITY:_____**STATE:**_____**ZIP CODE:**_____

POLICY HOLDE SEX: MALE/FEMALE **BIRTHDATE:**_____

POLICY HOLDER EMPLOYER:_____

SECONDARY INSURANCE

NAME OF INSURANCE_____**MEDICAID/MEDICARE/CHAMPUS**

GROUP #:_____**POLICY:**_____**EFFECTIVE DATE:**_____

RELATIONSHIP TO PATIENT: SELF HUSBAND WIFE DEPENDENT

COPAY AMOUNT:_____**DEDUCTIBLE AMOUNT:**_____

POLICY HOLDER NAME:_____

POLICY HOLDER ADDRESS:_____

CITY:_____**STATE:**_____**ZIP CODE:**_____

POLICY HOLDE SEX: MALE/FEMALE **BIRTHDATE:**_____

POLICY HOLDER EMPLOYER:_____

ASSIGNMENT OF BENEFITS: **I hereby agree, all medical and/or surgical benefits to which I am entitled including major medical. Medicare, Private insurance and any other plans to the office of North Georgia Nephrology Consultants, Dr. Abid Bashir. This agreement 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 authorized said assignee to release all information necessary to secure the payment.**

SIGNED_____**DATE**_____

MEDICAL ECORDS RELEASE FORM

DATE:_____

PLEASE RELEASE MY MEDICAL RECORDS TO:

NORTH GEORGIA NEPHROLOGY CONSULTANTS
ABID BASHIR, M.D.
JOLINA PAMELA C. SANTOS, M.D.
5105 JEFFERSON RD. SUITE B
ATHENS, GA 30607
PH: 706-227-4075 FAX: 706-227-4086

PATIENT'S NAME:_____**SSN:**_____

BIRTH DATE:_____

NAME AND ADDRESS OF DOCTOR FROM WHICH RECORDS ARE BEING REQUESTED.

_____

_____

_____

_____

_____

PATIENT'S SIGNATURE:_____

NORTH GEORGIA NEPHROLOGY CONSULTANTS
5105 JEFFERSON RD. SUITE B
ATHENS, GA 30607
PHONE: (706) 227-40725 FAX: (706)227-4086

Patient Consent Form For Use and Disclosure of Protected Health Information

By signing this Consent Form. You give us permission to use and disclosed protected health information about you for treatment, payment, and health care operations except for any restrictions specified below to which we have agreed. ***Protected health information*** is individually identifiable I information we create or receive, including demographic information, relating to your physical or mental health, for provision of healthcare services to you, and to the collection of payment for providing services to you.

Our Notice of Privacy Practices states that we may use and disclose protected health information about you. You have the right to receive a copy of our Notice of Privacy Practices before signing this Consent Form. As provided in the Notice, the terms of the revised copy by contacting our office. We will also answer any questions, or complaints you may have concerning your protected health information.

You have the right to request information on how protected health information is used or disclosed for treatment, payment, or healthcare operation. ***We are not required to agree to any restrictions, but if we do, we are bound by our agreement.*** If you wish to make a restriction, please request a copy of our Form to Request Restrictions.

If you do not sign the Consent form, we have the right to refuse you treatment unless a licensed healthcare professional has determined that you are require emergency treatment or we are required by l aw to treat you. We are required to document any circumstances in which we do not obtain your consent, yet carry out treatment. We will offer you a copy of this documentation should you decide to sign this Consent Form.

You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance to your ***prior consent.*** You may request to use our Authorization for Release of Information Form for purposes of requesting your revocation, or you may simply inform us in writing.

PATIENT NAME:_____

PATIENT'S REPRESENTATIVE:_____

SIGNATURE:_____**DATE:**_____

NORTH GEORGIA NEPHROLOGY CONSULTANTS
5105 JEFFERSON RD. SUITE B
ATHENS, GA 30607
PHONE: (706) 227-4075 FAX: (706) 227-4086

Consent For Medical Care And Treatment

I understand that I may have a medical condition that could possibly require diagnosis and treatment. I do voluntarily consent to such treatment, services, and procedures that may be recommended under the general specific instructions of the physician of North Georgia Nephrology Consultants.

I acknowledge that the practice of medicine is not an exact science and the physician of North Georgia Nephrology Consultants has made no guarantees to as to the results of treatment or examination.

North Georgia Nephrology Consultants recognizes the importance maintaining confidential information regarding a patient's medical condition. We also want to provide our patients with timely communication regarding laboratory or diagnostic test results. We understand that because of the patient's schedule and our office schedule this may sometimes be difficult. North Georgia Nephrology Consultants will not under any circumstances leave message regarding medical information.

Acknowledging that it may be difficult for the physician or his staff to personally communicate with the patients regarding laboratory or diagnostic test results. It is the policy of this office not to leave information on the patient's answering machine.

If the physician or the physicians staff cannot reach the patient at the home or business phone number. It is the policy of this office that a message will be left with the person that answers the telephone to advise the patient to return the phone call.

It is the policy of this office not to release any medical information to a patient's family members. We cannot discuss your medical condition, or release diagnostic test results to your spouse without your consent.

Information regarding my medical condition, including laboratory and diagnostic test results, can be given to my spouse. I AGREE_____I DO NOT AGREE_____

It is the policy of this office to participate in clinical research designed to improve the quality of patient care; this may necessitate the review of the patient’s medical records by research staff.

It is the policy of this office that all prescriptions needed to be refilled that you give us a 48-hour time-frame to get it filled.

Signature of Patient:_____Date:_____

NORTH GEORGIA NEPHROLOGY CONSULTANTS

Patient Medical Information

Patient Name:_____
Date of Birth:_____**Place of Birth:**_____
Sex: Male / Female Martial Status:_____**Religion:**_____
Date of last Physical exam:_____**Referred by:**_____

FAMILY HISTORY

	NAME	AGE	HEALTH PROBLEM
Father			
Mother			
Brothers/Sisters			
	M / F		
	M /F		
	M / F		
	M / F		

Only check if a blood relative has or has had any of the following and enter relationship:

- ☐ **Arthritis** _____
- ☐ **Bleeding Tendency** _____
- ☐ **Cancer** _____
- ☐ **Colitis** _____
- ☐ **Deafness**
- ☐ **at young age**_____
- ☐ **Diabetes**_____
- ☐ **Epilepsy**_____
- ☐ **Gout**_____
- ☐ **Heart Disease**_____
- ☐ **High Blood Pressure**_____
- ☐ **Kidney Disease**_____
- ☐ **Lupus**_____
- ☐ **Obesity**_____
- ☐ **Sickle Cell**_____
- ☐ **Stroke**_____
- ☐ **Tuberculosis**_____

OPERATIONS:
List and indicate approximate year:_____
_____
_____
_____

HOSPITALIZATIONS:
(Other than operations)
List reasons and approximate year

_____
_____
_____

Are you ALLERGIC to any medication: YES/NO
If yes, please list medications and reactions:

_____
_____
_____

Please list any medications that you discontinue because of intolerance or not being effective:

_____
_____

List any over-counter or Herbal medications:

_____
_____

PERSONAL HABITS:
Only check if you regularly smoke:

Drink Alcohol?_____

☐ **Cigarettes** **Occasional/Frequent/Rare**

☐ **Pipe** **Drink Coffee? YES/NO**
Cups per day_____

☐ **Cigars**

Number per day_____How many years have you been smoking_____

OCCUPATIONAL:
Are you presently employed? YES/NO Specify type and place of employment.

_____
Are you unable to perform any work because of a disability? YES/NO
Are you retired? YES/NO If yes, what was your occupation before?

_____

SOCIAL HISTORY
Have you recently lived or traveled outside the U.S. YES/NO
Were you rejected from the military? YES/NO
Have you ever been rejected for life or health insurance or had to pay an extra premium? YES/NO
Do you have or have had any alcohol or drug problems: YES/NO
Do you have a hobby or hobbies? YES/NO
Please List:_____

MARITAL

Has there been a recent change in your marital status? YES/NO

Do you have any sex problems: YES/NO

REVIEW OF SYTEMS

A. General

Do you usually feel tired or worn out? YES/NO

Have you recently been drinking more water or fluids? YES/NO

Have you recently noticed that warm or cold weather bothers you more? YES/NO

Has there been any weight gain or loss recently? YES/NO

Do you crave salt? YES/NO

Have you had any recent bee sting? YES/NO

Do you feel depressed a lot of the time? YES/NO

B. Skin

Have you noticed:

Frequent or recent skin infection? YES/NO

Any sores or wounds that do not heal? YES/NO

Any skin rashes or itching? YES/NO

Any changes in color or size of warts or moles? YES/NO

Any growth on your skin that bother you? YES/NO

Is your skin very sensitive to sun? YES/NO

C. ENT

Have you noticed:

Frequent or recent throat or ear infections? YES/NO

Drainage down the back of your throat? YES/NO

Any trouble hearing? YES/NO

Persistent hoarseness? YES/NO

Ringing or buzzing in your ears? YES/NO

Bleeding gums? YES/NO

Earaches? YES/NO

Unusual nasal stuffiness? YES/NO

D. Respiratory. Do you have:

Frequent chest colds? YES/NO

Sputum or phlegm between colds? YES/NO

A constant or bothersome cough? YES/NO

Difficulty breathing? YES/NO

Coughing up blood? YES/NO

Asthma? YES/NO

E. Cardiovascular

Do you have angina or heart attack? YES/NO

Do you have chest pain, tightness or pressure in your chest? YES/NO

Have you ever been told you have an irregular heartbeat? YES/NO

Do you have swelling of your feet or ankles? YES/NO

Do you have cramps in the calf muscles when you walk? YES/NO

Do you ever awaken at night with severe difficulty breathing? YES/NO

Do your fingers or toes ever get cold, become numb, or get very white or bluish? YES/NO

Do you get shortness of breath when laying flat? YES/NO

F. Gastrointestinal

Have you noticed a bad taste in your mouth YES/NO

Have you recently noticed and trouble swallowing? YES/NO

Do you have a lot of heartburn or indigestion? YES/NO

Have you ever vomited blood? YES/NO

Are you bothered with constipation? YES/NO

Do you have frequent loose stools or diarrhea? YES/NO

Do you have a stomach ulcer? YES/NO

Do you have a poor appetite? YES/NO

Have you ever had black or tarry stool? YES/NO

Do you take laxatives? YES/NO

Do you have frequent nausea and/or vomiting? YES/NO

Do you have any live problems or jaundice/ YES/NO

G. Genitourinary Do you have:

History of kidney stone? YES/NO

Any thing wrong with your genitals(privates)? YES/NO

Burning or pain when you urinate? YES/NO

To pass water frequently? YES/NO

Trouble starting urination? YES/NO

To get up at night to urinate? YES/NO

History of protein in urine? YES/NO

History of recurrent urinary tract infections? YES/NO

Trouble with using urine when you cough or sneeze? YES/NO

A problem with dribbling urine? YES/NO

Urgency to pass water? YES/NO

Do you pass less water than you need to? YES/NO

Have you ever passed blood in your urine? YES/NO

Have you ever had an operation to prevent pregnancy? YES/NO

(Vasectomy or sterilization, such as tubal ligation)

Men, do you have any prostate gland troubles? YES/NO

Do you get a feeling of incomplete evacuation after voiding urine? YES/NO

H. Musculoskeletal

Do you have any problems with back pain? YES/NO

Do you have joint pain, stiffness or swelling? YES/NO

Do you have pain in your legs or feet? YES/NO

Do you have pain in your bones? YES/NO

Do you have gout? YES/NO

I. Central Nervous System

Do you have frequent or severe headaches? YES/NO

Do you have trouble remembering recent events? YES/NO

Do you often have spells of dizziness, faintness or light-headedness? YES/NO

Have you ever had convulsions or fits? YES/NO

Have you lost vision suddenly for a short time? YES/NO

Do you have numbness or tingling in your head, arms or legs? YES/NO

Do you sometimes lose the ability to speak for a few seconds? YES/NO

Do you have any muscle weakness? YES/NO

J. Women Only

Is your menstrual periods regular? YES/NO

Do you bleed heavily or pass clots with your periods? YES/NO

Have you passed the menopause or change? YES/NO

Have you had any lumps in your breast? YES/NO

Have you had any discharge from your nipples? YES/NO

Are you using birth controls pills or estrogen? YES/NO

K. Miscellaneous

Do you have a history of:

- ☐ **Diabetes**
- ☐ **Anemia**
- ☐ **High Blood pressure**
- ☐ **Cancer**
- ☐ **Thyroid problems**
- ☐ **Systemic Lupus Erthematosus (Lupus)**
- ☐ **Bleeding or Clotting problems**
- ☐ **HIV Disease**
- ☐ **Malaria**
- ☐ **Venereal Disease**

ADDITIONAL COMMENTS

_____

_____

NORTH GEORGIA NEPHROLOGY CONSULTANTS

5105 Jefferson Road, Suite B
Athens, Ga. 30607
Phone: (706)227-4075
Fax: (706)227-4086

ABID BASHIR, M.D.

www.ngnccorp.com

700 Breedlove Drive, Suite D
Monroe, Ga 30655
Phone: (706) 227-4075
Fax: (706) 227-4086

Financial Policy

Dear patient,

You need to be aware that you are financially responsible for deductibles, co-insurance,co-pays or any amount not paid, not covered or denied by your carrier for the **Physician** before the day of your "Office Visit". **Please be prepared to make this payment at Your office visit or your visit can be rescheduled until further arrangements are made.** As a courtesy to you, North Georgia Nephrology Consultants will call and verify your coverage with your carrier.

If you have a HMO, PPO, POS please be aware there are differences in the policies, you make want to contact your insurance carrier before you scheduled visit.

It is responsibility as a patient to be aware of your coverage and how your plan works. Please remember that the policy is between you and your Insurance Carrier. If you have questions about your policy, call your Insurance Company for a detailed explanation of benefits.

Should you have any questions, please call the billing department at (706) 227-4075.

North Georgia Nephrology Consultants

I have read and agree to the above financial agreement.

_____ _____

Patient Signature Date

_____

Print Name

You must bring cash, check or a credit card to cover your copays or deductibles.

MAIN OFFICE	WINDER	MONROE	LOGANVILLE	GREENSBORO
5105 Jefferson Rd, Suite B	16 East Williams Street	700 Breedlove Drive Suite C	3431 Hwy 81	1040 Park Drive
Athens, Ga. 30607	Winder, Ga. 30680	Monroe, Ga. 30655	Loganville, Ga. 30052	Greensboro, Ga. 30642
706-227-4075	706-227-4075	770-207-5514	678-639-1633	706-227-4075
706-227-4086 FAX	706-227-4086 FAX	770-267-0327 FAX	678-639-1634 FAX	706-227-4086 FAX