NEPHROLOGY,
HYPERTENSION and DIALYSIS

Shoaib Chowdhury, MD / Arshad Ali, MD

8795 Pine Ridge Dr. Suite B / Cadillac, MI 49601
Phone 231-779-9960 Fax 231-779-8945

Date: _____

Dear: _____

You have been referred by your physician to see
Dr. Chowdhury / Dr. Ali in our _____office.
Your appointment is scheduled for _____ at _____ am/pm.

We **MUST** have a working number to contact you in case there is a need to reschedule your appointment. We have your number as _____. If this is not correct, please contact us right away with the correct number.

Please bring the completed paperwork to your first visit. You MUST bring your INSURANCE CARDS and MEDICATIONS with you to your appointment. IF YOU FAIL TO MAKE YOUR APPOINTMENT, THE OFFICE CANNOT GUARANTEE IMMEDIATE RESCHEDULING.

Please note you will be asked to provide a urine sample at this visit.

We look forward to assisting you in your kidney care. Thank You!

Cadillac Office	**Big Rapids Office**	**Manistee Office**	**Ludington Office**
8795 Pine Ridge Dr.	14307 Northland Dr.	1391 E. Parkdale	37 S. Pere Marquette Hwy
Suite B	Big Rapids, MI 49307	Manistee, MI 49660	Ludington, MI 49431
Cadillac, MI 49601			

WE ENCOURAGE YOU TO REQUEST THAT OUR PRACTICE BE NOTIFIED OF ANY ENCOUNTERS YOU HAVE WITH OTHER HEALTH CARE PROVIDERS AND FACILITIES.

Patient Name: _____ **Birthdate:** _____

Social Security #: _____ **Marital Status:** _____ **Age:** _____ **Sex:** _____

Address:_____

City:_____ **State:**_____ **Zip Code:**_____

Home Phone: _____ **Cell Phone:** _____

Email:_____

Would You Like an Invitation to Your Patient Portal (email address is required): Yes / No

Do You Want to Allow Email Message Reminders & Alerts: Yes / No

Would You Like to Opt-in to Text Messaging: Yes / No

What is Your Preferred Contact Method: _____

Who is Your Primary Care Physician: _____

Who Referred You to Our Office? _____

Your Place of Employment: _____

Allergies:_____

Preferred Pharmacy:_____

Emergency Contact: _____ **Phone:** _____**Relationship:**_____

Primary Insurance: _____

Primary Insurance Subscriber's Date of Birth: _____/_____/_____

Secondary Insurance: _____

Assignment of Benefits:

I authorize payment of Medicare and/ or insurance benefits be made on my behalf to Chowdhury MD, PLLC. I understand that I am financially responsible for all charges for services related to my visit including the balance remaining after insurance has been applied.

Signature:_____Date:_____

Release of Information:

I authorize Chowdhury MD, PLLC to release to the Health Care Financing Administration or its intermediaries/carriers, any information needed to determine benefits for this or any related claim. I permit a copy of this authorization to be used in place of this original document and understand that charges that are not covered by my insurance plan are my responsibility.

***The Health Care Financing Administration (HCFA) was created in 1977 to combine under one administration the oversight of the Medicare program, the Federal portion of the Medicaid program, and related quality assurance activities. (Information obtained from the Federal Register. Go to www.federalregister.gov for more information.)

Signature:_____Date:_____

Medication List

Name:_____ **Date of Birth:**_____

Allergies:_____

_____

Medication	Dose	Frequency

Name:_____ DOB:_____

Review of Symptoms (Check all that Apply)

	Cardiac		**Respiratory**
	Chest Pain		Shortness of Breath
	Heart Rhythm		Cough/Sputum/Phlegm
	Fainting/Blackouts		Wheezing
	Heart Murmur		Chronic Lung Disease
	Swelling		**HEENT**
	Leg/Buttock Pain		Serious Eye Problems
	Constitutional		Hearing Problems
	Trouble Sleeping		Wear Glasses
	Lack of Energy		**Hematologic**
	Appetite/Weight Changes		Bleeding Disorders
	Thyroid Problems		Anemia
	Fevers/Frequent Infections		Blood Clots
	Gastrointestinal		**Genito-Urinary**
	Nausea/Vomiting		Frequent Urination at Night
	Heartburn		Difficult Urination
	Constipation		Prostate Problems
	Blood in Stool		Blood in Urine
	Diarrhea		Loss of Bladder Control
	Swallowing Difficulties		**Neurologic**
	Abdominal Pain		Numbness/Tingling
	Musculoskeletal		Dizziness
	Difficulty Walking		Weakness
	Joint Pain/Swelling		Seizures
	Psychological		**Skin**
	Depression/Anxiety		Non-Healing Sores

HIPAA RELEASE FORM

Patient Name: _____ DOB: _____

Privacy regulations require us to have a release signed by our patients so we may speak with family members, friends and other relations regarding your medical treatment and patient financial information. Each person you wish to be considered a contact must be listed individually by name (including a Spouse or Significant Other).

Please print name, relationship, and telephone number for each person to whom you are authorizing release of your private health care information and account balances.

_____ _____ (_____)_____
Name Relationship Phone #

_____ _____ (_____)_____
Name Relationship Phone #

_____ _____ (_____)_____
Name Relationship Phone #

_____ _____ (_____)_____
Name Relationship Phone #

This authorization will expire on: ____/____/____ (fill in date if less than 1 year desired) or one year after being signed.

_____ _____
Patient Signature Date

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