**NEPHROLOGY AND HYPERTENSION ASSOCIATES**

**OXFORD NEPHROLOGY ASSOCIATES**

NEW PATIENT INFORMATION

DATE: _____

PATIENT NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE # _____ ALTERNATE # _____

MARITAL STATUS: _____ SEX: _____

AGE: _____ BIRTHDATE: _____ SOCIAL SECURITY #_____

EMERGENCY CONTACT: _____ PHONE: _____

EMERGENCY CONTACT RELATIONSHIP: _____

PLACE OF EMPLOYMENT: _____

WORK PHONE #: _____

SPOUSE NAME: _____

SPOUSE PLACE OF EMPLOYMENT: _____

SPOUSE WORK PHONE #: _____

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**HEALTHCARE PROVIDER INFORMATION & AUTHORIZATION TO RELEASE MEDICAL INFORMATION**

**REGULAR PHYSICIAN _____ CITY/STATE _____**

**PHYSICIAN WHO ARRANGED THIS VISIT FOR YOU: _____**

**CITY/STATE _____**

**PLEASE READ AND SIGN THE FOLLOWING AUTHORIZATION STATEMENT:**
**I authorize Nephrology and Hypertension Associates, LTD, its employees or agents, to forward my medical information to those persons listed above, and other healthcare providers who may be responsible for continuing my care.**

**PATIENT OR LEGAL GUARDIAN SIGNATURE: _____**

**Entered in Clinix by: _____**

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**NEW PATIENT INFORMATION**

**DO YOU HAVE A LIVING WILL OR OTHER ADVANCE DIRECTIVE ( ) NO ( ) YES**
**TYPE _____**

## MEDICATIONS

**Are you currently taking any prescription or nonprescription medications including vitamins, nutritional or "health food store" supplements, oral contraceptives, pain relievers, diuretics, or laxatives, and cold medicines?**

**Please list ALL medications that you are currently taking:**

**NAME OF MEDICTATION STRENGTH HOW TAKEN**

_____

_____

_____

_____

_____

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_____

_____

_____

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_____

_____

_____

_____

**ALLERGIES:** Have you every had an allergic reaction to Iodine or X-ray dye? ( ) YES ( ) NO

**NAME OF MEDICATION DESCRIBE ALLERGIC REACTION**

_____

_____

_____

_____

_____

Name: _____ Date: _____