Nephrology Associates of Montgomery County

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Stephen G. Vaccarezza, M.D.
Jeffrey A. Perlmutter, M.D.

Montrose Professional Park
6240 Montrose Road
Rockville, Maryland 20852

Patient Name____
(FIRST) (MIDDLE) (LAST)

Home Address____
(STREET)

____
(CITY) (STATE) (ZIP)

Telephone____
(HOME) (CELL) (WORK)

Email address____

Pharmacy:_______________________________Location:____________________________

Date of Birth_____________________Social Security Number___________________________

Who Referred you to this office?____

Patient's Employer____

Employers Address____

Occupation____

Are you: Single______Married________Divorced______Widowed_______

If married please complete the following:

Spouse's Name_____________________________________Occupation________________

Spouse's Employer's Name and Address: ____

____

Spouse's Work Phone____

Is your visit a result of: Auto Accident? _______Yes _______No
Job Injury? _______Yes _______No

In case of an emergency, whom should we contact?

Name______________________________________Relationship______________________

Daytime#____________________Cellphone________________Night________________

Do you have a living Will? _____Yes _____No

PATIENT AUTHORIZATION

I request that payment of authorized Medicare Benefits or benefits from ____________________ (Insurance Company Name) be made on my behalf to Drs. Vaccarezza and Perlmutter for any services furnished me by that physician or supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration or______________ (Insurance Company Name) any information needed to determine these benefits or the benefits payable for related services.

_________________________ ____
Date Patient Signature

Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name____

I hereby acknowledge that I received a Notice of Privacy Practices form from Nephrology Associates of Montgomery County.

_________________________ ____
Date Patient Signature

Nephrology Associates of Montgomery County has my permission to discuss my protected health information (PHI) with any healthcare professionals involved in my treatment and the following individuals:

_______________________________________ _____________________________________

_______________________________________ _____________________________________

_______________________________________ _____________________________________

Nephrology Associates may contact me at:

_____Home __________________________________Phone #

_____Work __________________________________Phone#

_____Other __________________________________Phone #

_____E-mail __________________________________E-mail Address

____ ______________________
SIGNATURE DATE

__________________****Patient has reviewed by not signed acknowledgement