**RESTON NEPHROLOGY AND HYPERTENSION**
**AHMAD O. NOORI**
*Diplomate, American Board Internal Medicine*
*Nephrology & Hypertension*
**1860 Town Center Dr., Ste. 280**
**Reston, VA 20190**
**Telephone: (703) 742-8500**
**Fax: (703) 742-9385**

## *Patient Registration*

*Last Name:* _____ *First Name:* _____ *Middle Initial:* _____

*Birth Date:* _____ *Age:* _____ *Sex:* _____ *Marital Status:* _____

*Social Security#:* _____-____-_____ *Ethnicity:* _____ *Race:* _____

*Primary Language:* _____ *Secondary Language:* _____

*Home Address* _____ *City* _____ *State* _____ *Zip* _____

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

*Employed By:* _____ *Work Phone:* _____

*Address:* _____ *City/State:* _____ *Zip:* _____

*In case of emergency who should be notified?* _____ *Relationship:* _____

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

*Who may we thank for referring you?* _____

*Do you have a Primary Care/Family Physician? If so, Please list:* _____

*Medical History*

*Any Allergies/Drug Allergies:* _____

*Past Surgeries:* _____

*Smoker:*_____ *Daily:*_____ *Alcohol use :*_____ *How Often:*_____

*Any Past or Current Conditions:* _____

_____

*Current Medications:*_____

_____

*Family History*

*Any Medical Conditions or Disorders? Please list below.*

*Patient Consent*

*The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain healthcare providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, or healthcare operations. As our patient we want you to know that we respect the privacy of your personal medical records and will do what we can to secure and protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your healthcare information and information about treatment, payment or healthcare operations, in order to provide healthcare that is in your best interest. We also want you to know that we support full access to your personal medical records. We may have indirect treatment relationship with you (such as laboratories that interact only with physicians and not patients) and may have to disclose personal health information for purposes of treatment, payment, or healthcare operations. These entities are most often not required to obtain patient consent. You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you chose to refuse to give your Personal Health Information (PIH). You may not revoke actions that have already been taken which relied on this or previously signed consent. If you have any objections to this form, please ask to speak with our HIPAA compliance officer. You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.*

*Print Name:*_____ *Signature:*_____ *Date:*_____

*Would you like our office to release your information to anyone else other than yourself? If so, please list them in the space provided below.*

*Name:*_____ *Relationship:*_____

*Name:*_____ *Relationship:*_____