

# Capital Nephrology Associates, P.A.

3031 New Bern Avenue Suite 306, Raleigh, North Carolina 27610  
Phone: 919-231-3966 Fax: 919-231-3912

Prabhakar N. Vaidya, MD  
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Sein Yin See, MD  
Deborah Siler, F.N.P

Date: \_\_\_\_\_

Dear \_\_\_\_\_,

You have been referred by your physician to be seen at Capital Nephrology Associates, PA.

Your appointment date: \_\_\_\_\_

Appointment time: \_\_\_\_\_

Your Provider will be: \_\_\_\_\_

Enclosed is our new patient information packet. It is important that you complete and bring with you to your appointment, along with the following:

- Current Picture ID,
- Current Insurance Card(s),
- Specialist Co-Pay,
- List Of Your Current Medications

If you should need to cancel or reschedule this appointment, please contact our office at 919-231-3966, at least 24 hours prior to your appointment date. We do charge a \$25 fee to all patients who do not give a 24 hour cancellation notice.

Please feel free to contact us if you should have any questions.

Thank you,

**Raleigh Office**  
3031 New Bern Ave Ste. 306  
(919) 231-3966

**Louisburg Office**  
216 N. Bickett Blvd. Ste. 5  
(919) 496-1977

**Zebulon Office**  
465 Stratford Drive  
(919) 231-3966

**North Raleigh Location**  
10010 Falls of the Neuse Road Ste 200  
(919) 231-3966

# Capital Nephrology Associates, P.A.

## NEW PATIENT INFORMATION SHEET

Section A

PATIENT CHART# \_\_\_\_\_

PATIENTS LEGAL NAME: \_\_\_\_\_

PREFERRED NAME: \_\_\_\_\_

SEX/GENDER: M \_\_\_\_\_ F \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_ SOC. SEC. # \_\_\_\_\_

PATIENT'S HOME ADDRESS: \_\_\_\_\_

COUNTY: \_\_\_\_\_

PATIENTS HOME PHONE # (w/area code): \_\_\_\_\_

PATIENTS CELL/MOBILE # (w/area code): \_\_\_\_\_

EMAIL ADDRESS: \_\_\_\_\_

RACE: \_\_\_\_\_

PREFERRED LANGUAGE: \_\_\_\_\_

### PREFERRED METHOD OF CONTACT

*Select as many as apply* ✓

EMAIL \_\_\_\_\_  
HOME PHONE \_\_\_\_\_  
CELL \_\_\_\_\_  
WORK \_\_\_\_\_

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SPOUSE'S NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

SPOUSE'S ADDRESS: (if not the same as above) \_\_\_\_\_

EMERGENCY CONTACT PERSON: \_\_\_\_\_ PHONE #: \_\_\_\_\_

EMERGENCY CONTACT RELATIONSHIP TO PATIENT \_\_\_\_\_

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EMPLOYED: YES \_\_\_\_\_ NO \_\_\_\_\_

PATIENT'S EMPLOYER: \_\_\_\_\_ WORK # (w/area code) \_\_\_\_\_ EXT. \_\_\_\_\_

EMPLOYER'S ADDRESS: \_\_\_\_\_

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REFERRING PHYSICIAN: \_\_\_\_\_ PHONE #: \_\_\_\_\_

PRIMARY CARE PHYSICIAN: \_\_\_\_\_ PHONE #: \_\_\_\_\_

REASON FOR REFERRAL: \_\_\_\_\_

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# Capital Nephrology Associates, P.A.

## INSURANCE INFORMATION

We cannot file your insurance without complete information and a copy of your Insurance Cards.

Please bring your Insurance Cards with you to every appointment.

### Section B

PATIENT NAME: \_\_\_\_\_

**(Primary)**

INSURANCE COMPANY: \_\_\_\_\_

ID # \_\_\_\_\_ GROUP # \_\_\_\_\_

#### ***IF POLICY HOLDER IS DIFFERENT FROM PATIENT:***

INSURED'S FULL NAME: \_\_\_\_\_ DOB: \_\_\_\_\_ EFFECTIVE DATE: \_\_\_\_\_

INSURED'S SOC SEC # \_\_\_\_\_

RELATIONSHIP TO PATIENT: SPOUSE \_\_\_\_\_ CHILD \_\_\_\_\_

#### **Office use ONLY**

Date Verified: \_\_\_\_\_

Verified By: \_\_\_\_\_

Active Coverage: \_\_\_\_\_ Effective Date: \_\_\_\_\_

Inactive Coverage: \_\_\_\_\_ Date of Termination: \_\_\_\_\_

**(Secondary)**

INSURANCE COMPANY: \_\_\_\_\_

ID # \_\_\_\_\_ GROUP # \_\_\_\_\_

#### ***IF POLICY HOLDER IS DIFFERENT FROM PATIENT:***

INSURED'S FULL NAME: \_\_\_\_\_ DOB: \_\_\_\_\_ EFFECTIVE DATE: \_\_\_\_\_

INSURED'S SOCIAL SECURITY # \_\_\_\_\_

RELATIONSHIP TO PATIENT: SPOUSE \_\_\_\_\_ CHILD \_\_\_\_\_

#### **Office use ONLY**

Date Verified: \_\_\_\_\_

Verified By: \_\_\_\_\_

Active Coverage: \_\_\_\_\_ Effective Date: \_\_\_\_\_

Inactive Coverage: \_\_\_\_\_ Date of Termination: \_\_\_\_\_

*I authorize Capital Nephrology Associates, P.A. to file claims to my insurance company on my behalf for services rendered to me by providers of Capital Nephrology Associates, P.A., Cary Nephrology Associates, or Capital Access Center.*

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

# Capital Nephrology Associates, P.A.

## Patient Medical Health History

Patient Name \_\_\_\_\_ Date: \_\_\_\_\_

Age: \_\_\_\_\_ Birth date: \_\_\_\_\_ Date of last physical exam: \_\_\_\_\_

What is your reason for your visit today? \_\_\_\_\_

SYMPTOMS check (✓) symptoms you currently have or have experienced in past years.

### General

- |   |   |
|---|---|
| <input type="checkbox"/> Weight Loss              | <input type="checkbox"/> Nausea/Vomiting      |
| <input type="checkbox"/> Weigh Gain               | <input type="checkbox"/>                      |
| <input type="checkbox"/> Night Sweats             | Constipation/Diarrhea                         |
| <input type="checkbox"/> TB Exposure              | <input type="checkbox"/> Ulcers               |
| <input type="checkbox"/> Shortness of Breath      | <input type="checkbox"/> Hepatitis            |
| <input type="checkbox"/> Asthma/Emphysema         | <input type="checkbox"/> Body Pain            |
| <input type="checkbox"/> Coughing up Blood        | <input type="checkbox"/> Weakness             |
| <input type="checkbox"/> Painful Breathing        | <input type="checkbox"/> Gout                 |
| <input type="checkbox"/> Chest Pains              | <input type="checkbox"/> Loss of Appetite     |
| <input type="checkbox"/> Chest Pressure           | <input type="checkbox"/> Increase of Appetite |
| <input type="checkbox"/> Chest Tightness/dizzy    | <input type="checkbox"/> Hair Loss            |
| <input type="checkbox"/> Lightheaded/Palpitations | <input type="checkbox"/> Thirsty              |
| <input type="checkbox"/> Blood Clots              | <input type="checkbox"/> Heavy Urination      |
| <input type="checkbox"/> Calf Pain                | <input type="checkbox"/> Blood In Urine       |
| <input type="checkbox"/> Cold Hands or Feet       | <input type="checkbox"/> Uncontrolled Urine   |
| <input type="checkbox"/> Smoker                   | <input type="checkbox"/> Weak Stream          |

### Skin

- Rash
  - Itching
  - Bruising
  - Moles
- ### Eye & ENT
- Blurred Vision
  - Glasses
  - Contacts
  - Eye Surgery
  - Nosebleeds
  - Trouble Swallowing
  - Ringing Ears
  - Trouble Hearing

### Conditions

- AIDS
- Alcoholism
- Anemia
- Anorexia
- Appendicitis
- Arthritis
- Asthma
- Diabetes
- Epilepsy
- Heart Disease
- Hepatitis
- Herpes
- High Cholesterol
- HIV Positive
- Migraine
- Headache
- Prostate Problem
- Thyroid Problem
- Tuberculosis
- Thyroid Fever

## Medical History

Please identify who was affect by condition: Mother, Father or Siblings

High Blood Pressure \_\_\_\_\_  
Diabetes \_\_\_\_\_  
Kidney Failure \_\_\_\_\_  
Kidney Stones \_\_\_\_\_  
Thyroid Disease \_\_\_\_\_  
Heart Failure \_\_\_\_\_  
Heart Attacks \_\_\_\_\_  
Kidney Ultrasound \_\_\_\_\_

Anemia \_\_\_\_\_  
Arthritis \_\_\_\_\_  
Gout \_\_\_\_\_  
Lupus \_\_\_\_\_  
Cancer \_\_\_\_\_  
Liver Disease \_\_\_\_\_  
Kidney Biopsy \_\_\_\_\_

Last time you had blood drawn was when and where? \_\_\_\_\_

List any allergies here: \_\_\_\_\_

*I hereby state, to the best of my knowledge, that these questions were answered truthfully. I understand the information is to be used to complete my medical history and to aid diagnosis and treatment process.*

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# Capital Nephrology Associates, P.A.

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## FINANCIAL ARRANGEMENTS AND INSURANCE

You will find that our fees for specialized care are comparable to other Nephrologist's in this area. If you have medical insurance to cover your expenses we will as a courtesy to you file your insurance. We are anxious to help you receive your maximum allowable benefits, and in order to achieve these goals we need your assistance and your understanding of our payment policy.

If you do not have medical insurance you are expected to pay for services incurred at time of service. We realize that individual financial situations may affect timely payment of your account. If this is the case you will be asked to talk to one of our account representatives to set up a regular payment plan for services incurred.

We will make every effort to maximize your insurance benefits, but you must understand the following:

- 1.) Your insurance coverage is a contract between you, and the insurance company. We are not a part of that contract.
- 2.) Insurance companies often judge a fee as "usual and customary" (UCR). As specialists in Nephrology, our fees are grouped in with other nephrologists for UCR calculation.
- 3.) Not all services are covered benefits in all contracts. Some insurance companies arbitrarily select certain services that they will not cover. You are responsible for knowing what is and is not covered under your plan.

We must emphasize that our relationship is with you as a patient not with your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered.

If you have any questions about the above information or any uncertainty regarding insurance coverage, please don't hesitate to ask to speak to a billing staff member. We are here to help you.

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*I have read, understand, and agree to the financial terms above. I agree to accept full responsibility for the payment of all fees.*

PATIENT/GUARDIAN'S PRINTED NAME: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

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## AUTHORIZATION TO DISCLOSE HEALTHCARE INFORMATION

Patient's  
Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Previous  
Name: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Authorized Individuals/organizations:

Name: \_\_\_\_\_ Address: \_\_\_\_\_

Name: \_\_\_\_\_ Address: \_\_\_\_\_

Name: \_\_\_\_\_ Address: \_\_\_\_\_

This request and authorization applies to:

- All healthcare information
- Healthcare information relating to the following treatment, condition, or dates: \_\_\_\_\_

Other  
(specify): \_\_\_\_\_

**Authorization:** I understand that authorizing the disclosure of this health information is voluntary. This authorization remains in effect for 2 years, unless revoked. I can revoke this authorization at anytime. To revoke I must do so in writing. I understand that the revocation will not apply to information that has already been released under this authorization. I understand that the information in my health records may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS) or HIV. It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

Patient Signature: \_\_\_\_\_ Date Signed: \_\_\_\_\_

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## RELEASE OF MEDICAL RECORDS

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Previous Name: \_\_\_\_\_ Social Security #: \_\_\_\_\_

### Physician Office Information:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

### This request and authorization applies to:

All healthcare information

Healthcare information relating to the following treatment, condition, or dates: \_\_\_\_\_

Other  
(specify): \_\_\_\_\_

**Definition:** Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereum, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

Yes  No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

Yes  No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature: \_\_\_\_\_ Date Signed: \_\_\_\_\_