MONTGOMERY RENAL ASSOCIATES, P.A.

Raymond Bass, M.D.
Vrinda Mahajan, M.D
Sorana Hila, M.D
Kathryn Ratanavanic, D.O

NEPHROLOGY / KIDNEY DISEASE

Thank your for choosing **Montgomery Renal Associates, P.A** for your medical care. in order to provide the most efficient health care to our patoents, enclosed in this packet you will find registrations form and our office policies.

For your first appointment with our office you will need to bring the following:

- All the forms attached in this packet, filled out.
- Upon arrival we request that you **LEAVE A URINE SAMPLE**.
- Insurance Cards, Photo I.D and if you have HMO insurance make sure you have a referral from your primary doctor.
  (Referrals are required at the time of service, or you will be **Financially RESPONSIBLE** for your visit in Full.)
- Please bring in an **UPDATED MEDICATIONS LIST**.

Please note, Co-Payments are required at the time service are rendered.
We accept Credit cards, Cash and Checks.

Please call the office if you have any further questions.
(301) 942-5355

MONTGOMERY RENAL ASSOCIATES, P.A.

Raymond Bass, M.D.
Vrinda Mahajan, M.D
Sorana Hila, M.D
Kathryn Ratanavanic, D.O

PATIENT REGISTRATION

Patient Name: *First* *Middle* *Last*

Date of Birth: Occupation:

Address:

Apt Number: City State ZIP

Gender: Phone: Alternate Phone:

Marital Status: SSN# Email:

Emergency Contact Name: Relation:

Emergency Contact Number:

Can we Shared Medical Informationwith Emergency Contact? ☐ Yes ☐ No

Primary Care Physician: Phone:

Preffered Pharmacy Name: Phone:

Address:

BILLING & INSURANCE INFORMATION

Billing Information

Name: *First* *Last* Relation to Patient

Address:

City: State ZIP Phone:

Employer: Work Phone:

Primary Insurance: Insurance Company Name:

ID or Policy # Group/Code Date Effective:

Address:

Subscriber's SSN# Name:

Gender: Home Phone: Relation with Patient:

Subscriber's Date of Birth: Work Phone:

Secondary Insurance: Insurance Company Name:

is this through Group/Code Date Effective:

Address:

Subscriber's SSN# Name:

Gender: Home Phone: Relation with Patient:

Subscriber's Date of Birth: Work Phone:

MONTGOMERY RENAL ASSOCIATES, P.A.

Raymond Bass, M.D.
Vrinda Mahajan, M.D
Sorana Hila, M.D
Kathryn Ratanavanic, D.O

PATIENT REGISTRATION

PATIENT INFORMATION *PLEASE FILL OUT THE FORM AS ACCURATELY AS POSSIBLE.*

Patient Name: _____
First *Middle* *Last*

Date of Birth: _____ Gender: _____ Phone: _____ ☐ Cell ☐ Home

Alternative Phone: _____

Referring Provider: _____ Phone: _____

Reason Referal: _____

PLEASE LIST MEDICINES INCLUDING OVER THE COUNTER (Non, Prescriptions)

NAME	DOSAGE	HOW OFTEN

LIST ANY DRUG ALLERGIES AND TYPE OF REACTION:

IMMUNIZATIONS (Any Received)

☐ Measles ☐ Mumps ☐ Pneumonia ☐ Hemophilus ☐ Hepatitis ☐ German Measles ☐ Smallpox

☐ TB Skin Test: _____ ☐ Positive ☐ Negative Last Flu Shot _____

HAVE YOU BEEN EXPOSED TO CHEMICALS, TOXINS POISONS, FUMES SMOKE OR RADIOACTIVE MATERIALS AT HOME OR/WORK? ☐ Yes ☐ No

How often: _____ Types: _____

MONTGOMERY RENAL ASSOCIATES, P.A.

Raymond Bass, M.D.
Vrinda Mahajan, M.D
Sorana Hila, M.D
Kathryn Ratanavanic, D.O

PATIENT REGISTRATION

SOCIAL HISTORY

Do you use tobocco? ☐ Yes ☐ No

if Yes, What Kind? ☐ Chew ☐ Smoke How much:

Do you drink alcohol? ☐ Yes ☐ No

Do you use drugs? ☐ Yes ☐ No

Do you drink caffeinated beverages? ☐ Yes ☐ No

Do you have difficulty sleeping? ☐ Yes ☐ No

Do you excercise reguarly? ☐ Yes ☐ No

Marital Status: Occupation: Education Level:

Check if you have, or ever had, any of the following conditions:

- ☐ Blood in Urine
- ☐ Protein/Foamy urine
- ☐ Urination at night
- ☐ Frequent urination
- ☐ Kidney/bladder infection
- ☐ Pain or burning with urination
- ☐ Difficulty urinating Childhood
- ☐ Nephritis
- ☐ Kidney stones
- ☐ Unexpected weight change
- ☐ Irregular or Fast heart beat
- ☐ Chest pain or Tightness
- ☐ Frequent swelling of ankles or legs
- ☐ Unusual or Severe Shortness of breath
- ☐ Unusual skin problems or persistent sores
- ☐ Redness, severe pain, or swelling of joints
- ☐ Changes in appetite
- ☐ Frequent or severe back pain
- ☐ Difficulty swallowing
- ☐ Frequent or severe abdominal pain
- ☐ Frequent Nausea or Vomiting
- ☐ Frequent or Severe constipation/diarrhea
- ☐ Kidney Transplant
- ☐ Blood in bowel movements
- ☐ Black or tarry stools
- ☐ Frequent or Severe heacaches
- ☐ Other:_____

Blood Transfusion: ☐ Yes ☐ No When:_____

☐ Consistent use of Non- Steroidal (Motrin, Ibuprofen, Aleve, Naproxen, Excedrin)

MONTGOMERY RENAL
ASSOCIATES, P.A.

Raymond Bass, M.D.
Vrinda Mahajan, M.D
Sorana Hila, M.D
Kathryn Ratanavanic, D.O

PATIENT REGISTRATION

FAMILY HISTORY

CHECK ( ) IF THERE IS ANYONE IN YOUR IMMEDIATE FAMILY (Father, Mother, Sister or Brother) WITH A HISTORY OF:

- ☐ Chronic Kidney Disease Who?
- ☐ Diabetes
- ☐ High blood Pressure
- ☐ High Cholesterol
- ☐ Cancer
- ☐ Gout
- ☐ Birth defects
- ☐ Bleeding Problems
- ☐ Seizures
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Lupus

What Questions do you wish to ask the Doctor?

Patient Name: _____

Signature: _____ **Date:** _____

3941 Ferrara Drive
Wheaton, Maryland 20906
(301) 942-5355
(301) 942-5240

15225 Shady Grove Rd. Suite 104.
Rockville, Maryland 20850
(301) 330-0550
(301) 330-0588

MONTGOMERY RENAL
ASSOCIATES, P.A.

Raymond Bass, M.D.
Vrinda Mahajan, M.D
Sorana Hila, M.D
Kathryn Ratanavanic, D.O

PATIENT REGISTRATION

PATIENT AUTHORIZATION

I, hereby authorize Montgomery Renal Associates P.A. to apply for benefits on my behalf for covered. I request payment from BC/BS National Capital Area, Medicare, and or_____(Name of other Ins. Co.) Insurance company, be made directly to the above-named provider (or, incase Medicare Part B benefits, to myself or the Party who accepts assignment). I certify that this information have reported with regard to my Insurance coverage is correct and further authorize to release any necessary information, Including medical information for this or any related claim to the above-named billing agent (or in the case of medicare part B benefits to the Social Security Administration and Health care Financing administration) and or the insurance company named above. I permit copy of this authorization to be used in place of the original. This authorization may be revoked by either me or the above-named carrier at any time in writing. I request that payment of authorized Medigap benefits be made either to me or on my behalf to the above-named provider for any services furnished to me by the Physician/Supplier. I authorize any holder of medical information about me to release to _____(named of Medigap carrier) any information needed to determine these benefits payable related services.

Date: _____

Signature of Subscriber or beneficiary: _____

GENERAL MEDICAL INFORMATION

Describe current medical problems:

Previous or Other Medical problems:

3941 Ferrara Drive
Wheaton, Maryland 20906
(301) 942-5355
(301) 942-5240

15225 Shady Grove Rd. Suite 104.
Rockville, Maryland 20850
(301) 330-0550
(301) 330-0588

MONTGOMERY RENAL
ASSOCIATES, P.A.

Raymond Bass, M.D.
Vrinda Mahajan, M.D
Sorana Hila, M.D
Kathryn Ratanavanic, D.O

PATIENT REGISTRATION

CANCELLATION/ NO SHOW POLICY

Please be advised that we now require a minimum of 24 hours notics for cancellation of office visits.

Failure to provide us with 24 hours notice will result in a fee of $50.00.

Patient Signature: _____ Date: _____

3941 Ferrara Drive
Wheaton, Maryland 20906
(301) 942-5355
(301) 942-5240

15225 Shady Grove Rd. Suite 104.
Rockville, Maryland 20850
(301) 330-0550
(301) 330-0588