Mahendra Agraharkar, MD FACP FASN
Geetha Seerangan, MD

Space City Associates of Nephrology
560 Blossom Street, Ste C
Webster, Texas 77598
Ph # (832)-905-6141
Fax # (832)200-3259

RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM

I_____, have been informed of Mahendra Agraharkar MD's Notice of Privacy Practices.

_____ _____
Signature of Patient/Guardian **Date**

Patient Registration

Name_____**Date**_____

Address_____

_____

(City) (State) (Zip)

Home Phone #_____**Mobile Phone #**_____

Email Address _____

Social Security #_____**Birthdate** _____**Age** ____**Sex** _____

Marital Status_____**M**_____**Single**_____**Divorced**_____**Sep**_____**Widowed**

Language _____**Race** _____**Ethnicity** _____

Spouse Information

Spouse's Name _____**Occupation**_____

Spouse Employer _____**Phone**_____

Emergency Contact (other than spouse)

Name_____ **Relationship** _____

Phone # _____ **Alternate Phone #** _____

Insurance Information

Primary Insurance _____**Phone**_____

Policy Number _____**Group Number**_____

Secondary Insurance _____**Phone #**_____

Policy Number _____**Group Number**_____

Primary Care Physician Information

Name _____

Phone # _____ **Fax #** _____

Pharmacy Information

Preferred Pharmacy _____

Location _____
(City) (State) (Zip)

Phone # _____ **Fax #** _____

Allergies _____

_____

Employee Information

Employer_____**Occupation**_____

Employer's Address_____

_____
(City) (State) (Zip)

Phone # _____ **Fax #** _____

_____ _____
Signature of Patient/Guardian **Date**

AUTHORIZATION FOR RELEASE
OF MEDICAL INFORMATION

Patient Name_____
Last **First** **Initial**

Address_____
Street

_____
City **State** **Zip**

_____
Social Security Number **Date of Birth**

I hereby request_____

_____
Street

_____
City **State** **Zip**

_____
Phone Number **Fax Number**

To furnish a copy of all available medical records of the patient named above to:

Space City Associates of Nephrology
560 Blossom Street, Ste C
Webster, Texas 77598
Ph # (832)-905-6141
Fax # (832)200-3259

_____ I authorize the release of all information, including information regarding HIV testing, AIDS information, substance abuse, alcohol use, psychiatric disorders that me be included in my medical record. I hereby release your physician and staff from liability following this authorization and release.

_____ _____
Signature of Patient/Guardian **Relationship to Patient**

_____ _____
Witness Signature **Date**