NEPHROPHILES, LLC

ELITE KIDNEY & HYPERTENSION SPECIALISTS OF NEW MEXICO

C.Gentiana Voinescu, MD **Alexandra (Sanda) Voinescu, MD**

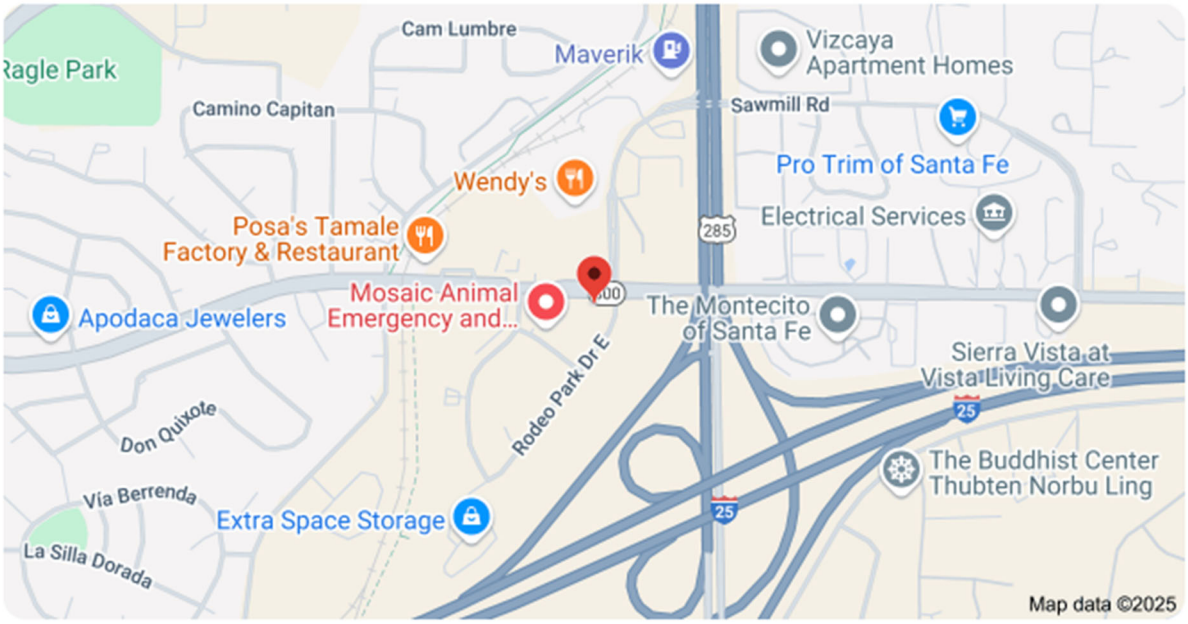
Charnes S.Chiu **Tudor S Ocneanu, MD**

William Vasquez Espinosa,MD

Our Location:

2904 Rodeo Park Dr E Ste 300B

Santa Fe NM 87505



Please Remember:

- **Bring ALL your medications (Bottles)**
- **Bring Paperwork filled out**
- **Bring CURRENT insurance cards**
- **Arrive 30 Minutes prior to your scheduled appointment**
- **Please give 24 hr notice for cancellation (to avoid NO SHOW/LATE CANCELLATION FEE of $100)**

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Tudor Ocneanu, MD PC Alexandra I. Voinescu, MD PC (Sanda)
William Vasquez Espinosa, MD

REGISTRATION FORM

TODAY'S DATE _____/_____/_____ **CHART #_____**

LAST NAME/APELLIDO	FIRST NAME/NOMBRE	MIDDLE INITIAL

SOCIAL SECURITY #/ NUMERO DE SOCIAL	DATE OF BIRTH/DIA DE NACIMENTO	SEX/SEXO	MARITAL STATUS/ESTADO CIVIL
	_____/_____/_____	F ___ M ___ Transgender ____ Intersex _____ Other _____	[ ] Single [ ] Married [ ] Divorced [ ] Widowed [ ] Legally Separated

PREFERRED LANGUAGE/	ETHNICITY/ETNIA	RACE/CERRERA
[ ] English [ ] Spanish [ ] Other_____	[ ] Hispanic/Latino [ ] Not Hispanic/Latino [ ] Unknown	[ ] American Indian/Alaska Native [ ] Asian [ ] Black/African American [ ] White [ ] Native Hawaiian/Other Pacific [ ] Other

MAILING ADDRESS/DIRECCION DE ENVIO		
CITY/CIUDAD	STATE/ESTADO	ZIP + 4 DIGIT/CODIGO POSTAL

PATIENT HOME PHONE/ TELEFONE DE CASA	EMERGENCY CONTACT/CONTACTO DE EMERGENCIA	RELATIONSHIP/ RELACION	PHONE NUMBER/ NUMERO DE TELEFONO
( )			

PATIENT CELL PHONE/ TELEFONE MOVIL	PATIENT EMPLOYER/EMPLEADOR PACIENTE
( )	

PATIENT E-MAIL ADDRESS/ DIRECCION DE CORREO ELECTRONICO	PRIMARY INSURANCE/ SEGURA PRIMARIO	SECONDARY INSURANCE/ SEGURA SECUNDARIO

Referring Provider:	Specialty		Phone Number	Fax Number
Primary Care Provider (PCP)	**Specialty**		**Phone Number**	**Fax Number**
Additional Provider:	**Specialty**		**Phone Number**	**Fax Number**

KIDNEY TRANSPLANT PATIENT?

[ ] YES [ ] NO

ASSIGNMENT OF BENEFITS

I hereby authorize insurance payment directly to the physician who I receive medical care from located at 2904 Rodeo Park Dr East Ste 300B, Santa Fe, NM 87505. I understand that medical claims will be filed on my behalf to my insurance carrier as a courtesy to me. I understand that I am financial responsible to my physician for charges not covered by this assignment of benefits such as co-pay, co-insurance, deductible, and non-covered benefits as processed by my insurance carrier.

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize my physician, his staff or designee to release any information including information regarding diagnosis and treatment as requested by my insurance company to collect benefits available for services rendered. Unless noted otherwise, this authorization includes but is not limited to, the release of information related to drug, alcohol, HIV antibody and/or psychiatric treatment and/or testing.

PATIENT SIGNATURE	DATE SIGNED _____/_____/_____

CHART #: _____

Welcome to Nephrophiles,LLC
Elite Kidney and Hypertension Clinic

OUR COMMITMENT TO YOU

Our office team will strive to check you in promptly so that you are seen by your doctor as quickly as possible. We are committed to timely service. It is important to us that you notify the front desk if you have been waiting more than 15 minutes. Our physician staff is committed to responding to urgent problems as they may arise. The physicians will break from normal appointments to respond to emergencies. Should you have an urgent problem, we will make every effort to see you responsibly and quickly.

It is important to us that you share feedback about your experience while visiting or contacting our office. If you encounter any problems, we welcome your call to our Office Manager Jaclyn Abeyta at 505-216-3735.

HOW TO REACH US

Our office hours are Monday through Friday, 8:00 AM to 5:00 PM. We offer continuous telephone and access to the office during our business hours. A physician is available 24 hours, 7 days a week and can be reached any time of day or night by calling our main office at 505-216-3466

INSURANCE AND FINANCIAL RESPONSIBILITY

At the time of check-in you are asked to please present your current insurance information and pay your co-pay or co-insurance. You are responsible for any deductibles you may have with your health plan. If we are not contracted with your health plan, **payment in full is expected at the time of your visit**. As a courtesy to you, we will submit a claim for your allowed reimbursement from your health plan.

If you do not have insurance, please ask to speak to the Office Manager immediately upon check in. We will make every effort to establish a fair payment plan for you. We do expect you to pay for the services you receive in our office. We do not turn away anyone in need of medical services regardless of patients' ability to pay.

PATIENT RESPONSIBILITIES

Your care is very important to us. Our staff puts in a significant amount of time to make sure your chart is ready for review upon your arrival. We ask that you do any LABS or any other orders 7 days prior to your appointment. Please bring in all your current medications **(in original bottles)** to **EVERY** appointment. We ask that you show up 20 minutes prior to your scheduled appointments with our physicians. If you **NO SHOW** for your schedule NEW Patient appointment you will be dismissed from the practice and referred to the nearest Nephrologist. Your health is very important to us and we want to give the best possible care.

PRESCRIPTION REQUESTS

Please plan your prescription refill requests at the time of your visit. Our Physicians ask that you have a list of all medications that will need refills to get you till your next follow up. If you need a prescription outside of an appointment, please contact your pharmacy who will make contact with our office for approval. Please allow **48 hours** for your pharmacy to process your request before contacting our office. If you need a mail order prescription refilled, please contact our office directly.

OXYGEN USE

Please notify the Medical Assistant if you use oxygen at home and did not bring it with you to your appointment.

Thank you for the opportunity to serve you.

_____

PRINT NAME

_____ _____/_____/_____

PATIENT SIGNATURE **DATE**

Late Cancellation and No- Show Policy

NEPHROPHILES, LLC
ELITE KIDNEY & HYPERTENSION SPECIALISTS OF NEW MEXICO

PLEASE READ THIS FORM TO COMPLETION. Nephrophiles is mindful that emergencies and mistakes sometimes happen. We require all of our patients to understand and comply with our Late Cancellation/ No-Show Policy.

Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. At times our WAIT LIST runs over 100 patients seeking appointments reserved by others. Thus, its essential that all patients come in for the appointments they reserve, and abide by this clear policy.

For Late Cancelation and/ or No-Show fees of 100.00 (UPDATED 8/12/2025)

Late Cancelation and No Show (LC/NS) fees may be charged beginning the date the LC/NS fee is incurred. To Ensure our patients do not incur these fees, you will receive a call reminder 1 week prior and 1 day before your scheduled appointment. **We ask for a 24-hour notice of a cancellation or reschedule.**

By signing below, I acknowledge Nephrophiles Late Cancellation/ No-Show Policies are clearly described above. I agree to abide by these policies and understand if I late Cancel/ No-Show to appointment(s) at Nephrophiles fee(s) will be due and collected as described herein.

By Signing this document, I acknowledge I will incur a charge if I NO SHOW or Late cancellation for my scheduled appointment.

Patient Name **PRINTED**: _____

Patient/Guardian **Signature:** _____

Date: _____

Effective 08/12/2025

Chart # _____

FIRST VISIT: _____ ***Please circle any positive symptoms listed below:***

Name: DOB: / / Today's date:

1.HOW ARE YOU FEELING TODAY:

Have you been in the hospital recently? Yes No -If yes what was the reason!

Are you able to urinate? **1.Same as usual 2. More than usual 3. Less the usual**

Is your urine: **clear –yellow dark-yellow cloudy red like Coca-Cola**

Do you have: blood in the urine? frothy urine? pain while urinating?

Have you had any infection in the urine recently? Yes No

Do you have the sensation of not emptying your bladder completely after you finished urinating? Yes No

Have you found it difficult to postpone urination? Yes No

Do you have to push or strain to begin urination? Yes No

Do you have a weak urinary stream? Yes No

Are you losing (leaking) urine with cough or exercise Yes No

Do you have to urinate during the night? Yes No If yes! How many times?.....

Do you have pain around your kidneys (flanks)? Yes No If yes 1. Right 2. Left 3. Both

Do you eat with salt? 1.None 2.A little 3. Moderate 4.A lot!

How much water/liquids do you drink per day?.....

Do you have swelling in your legs? 1.No 2. Some 3. Moderate 4. a lot

The swelling in your legs is it getting: 1. Worse 2. Better 3. Did not change in the last period of time

Did your weight change recently? 1. No change 2. Gained weight 3. Lost weight

Do you feel short of breath? 1.No 2. Some 3. Only when I walk 4. At rest 5.All the time 6.Only when I am lying flat

Is it getting: 1. Worse 2. Better 3. Did not change in the last period of time

Your appetite is: 1. Normal 2. Decreased 3. Nonexistent 4. Increased

How many times do you miss your medications per week?

1.Never 2. One time /week 2.Two times /week 3. More than two times /week

Do you check your blood pressure at home? Yes No If yes, what are the values?...../.....

Do you check your blood sugar at home? Yes No If yes, what are the values?.....

Do you take any medications like: Motrin, Ibuprofen, Advil, Aleve, Naproxen, Celebrex, Indomethacin, ALFA-LIPOIC Acid

other pain killers: -**please list:**

Do you take any other medication/ supplements other than prescribed? **Yes** **No**

If yes which ones?-

Were you prescribed any new medication lately (last month)? ***Yes*** ***No***

If yes please list:

Have you been in the hospital recently? ***Yes*** ***No*** ***-If yes what was the reason!***

Have you had any procedures done recently? ***Yes*** ***No*** ***-If yes-please list:***

General: **F**ever **F**atigue/Tired **C**hills **W**eakness

Eyes: **D**ecreased vision **E**ye pain **E**ye redness **D**ouble vision **D**ry eyes

Ears/Nose /Throat: **D**ecrease hearing **Ear** pain **Ear** drainage **S**inus problems **S**ore throat **N**ose bleeds **N**ose drainage **H**eadaches **H**oarseness **B**uzzing in your ears Dizziness **T**eeth pain or infections

Respiratory: **C**ough **Sputum:** white yellow green bloody **W**heezing **N**ight Sweats

Can you take a flight of stairs without feeling short of breath? **Yes** **No**

Cardiac: Chest pain/pressure within the last 4 weeks **P**alpitations **P**ain in your calves while walking**?**

Do you get up in the middle of the night because of shortness of breath? **Yes** **No**

Gastro: Metallic taste **A**bdominal pain **N**ausea **V**omiting **H**eart burns **D**iarrhea Constipation **B**loody or Black stools **T**rouble swallowing

Joints/Muscles: Back pain Neck Pain Joint pain **J**oint swelling **M**uscle pain **L**eg Cramps

Skin changes: Rashes **I**tching

Neurological: **N**umbness **T**remor **T**ingling **S**eizures **M**emory loss **J**erking movements Fainting

Psych/ Sleep: **D**epression Insomnia **S**leepiness **S**noring **D**ay time drowsiness Anxiety

Endocrine: Heat intolerance **Increase** thirst **I**ncrease water/fluid intake **H**air loss Too much hair

Hematologic: Bleeding gums **E**asy bruising **E**nlarged lymph nodes **B**one pain

Allergy: **S**easonal allergies Hives

Please list any other significant problems that are bothering you:

Have you had:	When did it start?	**Medications Changes:**
Diabetes		
High blood pressure		
Heart Attack /Heart surgery		
Heart Failure		
Stroke Seizures		
Vascular problems		
Kidney problems		
Kidney stones		
Urinary infections		
Recent Infections		
Autoimmune Disease(like Lupus or MS)		
Hepatitis: A B C		
Gout		
Lung disease		
Stomach /Colon Problems		
High Cholesterol		
Others significant problems:		

Are you **Right** Handed **Left** Handed ?
Have you had vaccination for : 1. HEPATITIS B 2. FLU 3. PNEUMONIA(PNEUMOVAX)

Family History: please check	**Nobody**	**Father**	**Mother**	**Sibling**	**Other family members**
Diabetes					
Heart Attack					
Kidney Disease, hemodialysis or transplantation					
Kidney stones:					
High blood pressure					
Stroke					
Autoimmune Disease (like Lupus or MS)					
Gout					
Other major health problem:					