

Endocrine and Diabetes Associates, LLC

PATIENT INFORMATION		Patient Name:	SSN:	DOB: / /	Sex:	Marital Status:
*Race: <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American			<input type="checkbox"/> White <input type="checkbox"/> Native Hawaiian	<input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Other <input type="checkbox"/> Prefer not to specify	*Ethnicity: <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Prefer not to specify	
*Preferred Language:		Street Address	Home #	Cell #		
City, State, Zip		Preferred method of contact: <input type="checkbox"/> Cellphone / SMS (text) <input type="checkbox"/> Home phone				
Employer						
Primary Care Physician	Referring Physician	Personal email:				
PHARMACY NAME & PHONE NUMBER (LOCAL and/or MAIL ORDER)						
FINANCIALLY RESPONSIBLE PARTY (IF MINOR OR DEPENDENT)						
Guarantors Last Name:	First Name	MI	Work#			
Street Address	City, State, Zip		Home#			
Employer	Employer Address					
PRIMARY INSURANCE INFORMATION						
Insurance Company	ID#	Group#				
Policy Holder's Name	Policy Holder's DOB	Policy Holder's SSN				
Policy Holder's Employer	Patient Relationship to Policy Holder	Insurance Effective Dates			Visit CoPay	
SECONDARY INSURANCE INFORMATION						
Insurance Company	ID#	Group#				
Policy Holder's Name	Policy Holder's DOB	Policy Holder's SSN				
Policy Holder's Employer	Patient Relationship to Policy Holder	Insurance Effective Dates			Visit CoPay	
EMERGENCY CONTACT						
Name	Phone			Relationship		
1. FINANCIAL RESPONSIBILITY I certify that the information I have provided regarding my insurance coverage is correct and authorize Endocrine & Diabetes Associates to verify the insurance coverage and benefits allowed in accordance with my insurance plan's policies. I authorize that payment be made directly to Endocrine & Diabetes Associates for all medical benefits which are payable under the terms of my insurance policy for the services provided. I agree to pay copayments, coinsurance, or deductible, are required by my insurance plan. I understand that I am responsible for knowing the terms and regulations of my insurance plan, and I agree to accept full responsibility for payment if my insurance plan is invalid. I will be responsible for all lab charges denied for insurance payment if I have not notified Endocrine and Diabetes Associates of lab billing problems within 10 days of receiving a bill from the laboratory. I will be charged a \$75 fee for appointments missed without 24 hours' notice. I will be assessed a \$40 fee for any check returned by my bank. An account unpaid after repeated notification will be forwarded to Transworld Systems for collection. A collection fee of 40% and a processing fee of \$9.50 will be assessed.						
2. RELEASE OF MEDICAL INFORMATION I hereby authorize Endocrine and Diabetes Associates to retrieve my prescription drug history. They may submit a claim to my insurance company for medical services provided to me or my dependant, to provide a copy of this release and a copy of medical records related to such services if requested by the payer, and to release medical information to my primary care or consulting physicians to assist with continuity of my health care. This release will remain in effect until I cancel this release in writing.						
3. NON-COVERED SERVICES I agreed to pay for medical services provided to me or my dependant which are not covered by the benefits in my insurance plan.						
I Agree To The Above Stated Responsibility and Consent:						
_____ Signature of Patient or Legal Guardian			Date: _____			

Endocrine and Diabetes Associates, LLC

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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

PATIENT NAME _____

DATE OF BIRTH: _____

SOC SEC or ID # _____

I hereby authorize _____
(name of your doctor or facility)

FAX# _____

(address)

to furnish information from my medical records, to include history/exam, laboratory and/or radiology reports, and any information pertinent to my **appointment** provider at Endocrine and Diabetes Associates, LLC.

This authorization shall expire without my express revocation one year from the date written below. I understand that I have the right to withdraw this authorization at any time, except to the extent that action has been taken on this authorization

Signature of Patient or Guardian

Date

HEALTH HISTORY

Confidential

Patient Name _____ Today's Date _____

Age _____ Birth Date _____ Date of Last Physical Examination _____

What is your reason for visit? _____

SYMPTOMS - Check (✓) symptoms you currently have or have had in the past year.

GENERAL

- Chills
- Depression
- Dizziness
- Fainting
- Fatigue
- Fever
- Forgetfulness
- Headache
- High/low blood sugar
- Loss of sleep / poor sleep
- Nervousness
- Numbness
- Sensitivity to cold or heat
- Sweats
- Tremors
- Weight loss / gain

GENITO-URINARY

- Blood in urine
- Frequent urination
- Lack of bladder control
- Painful Urination
- Urination at night

GASTROINTESTINAL

- Appetite poor
- Bloating
- Bowel changes
- Constipation
- Diarrhea
- Excessive hunger
- Excessive thirst
- Gas
- Indigestion / Reflux
- Nausea
- Rectal bleeding
- Stomach pain
- Vomiting

CARDIOVASCULAR

- Chest pain
- High blood pressure
- Irregular heart beat
- Low blood pressure
- Rapid heart beat
- Swelling of ankles
- Varicose veins

EYE, EAR, NOSE, THROAT

- Blurred vision
- Difficulty swallowing
- Double vision
- Earache
- Hoarseness
- Loss of hearing
- Persistent cough

SKIN

- Hives
- Itching
- Rash
- Sore that won't heal

MEN only

- Breast enlargement
- Breast lump
- Erection difficulties
- Lump in testicles
- Penis discharge
- Poor libido
- Sore on penis
- Other _____

WOMEN only

- Abnormal Pap Smear
- Bleeding between periods
- Breast lump or tenderness
- Hot Flashes
- Painful intercourse
- Poor libido
- Nipple Discharge
- Vaginal Discharge
- Other

Date of Last Menstrual Period _____

Date of Last PAP Smear _____

When was your last mammogram? _____

Are you Pregnant? _____

CONDITIONS - Check (✓) conditions you have or have had in the past.

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> AIDS / HIV Positive | <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> High Cholesterol/High Lipids | <input type="checkbox"/> Seizure |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Kidney Disease / Stones | <input type="checkbox"/> Sexually transmitted disease |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Liver Disease/ Hepatitis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Eating disorder | <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Suicide attempts |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Breast Lump | <input type="checkbox"/> Goiter | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Gout | <input type="checkbox"/> Polio | <input type="checkbox"/> Vaginal Infections |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Prostate Problem | |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Psychiatric Care | |

MEDICATIONS List medications you are currently taking.

Pharmacy Name _____

Phone number _____

ALLERGIES To medications or substances.

None

FAMILY HISTORY Fill in information about your immediate family.							
Relation	Current Age	Year Of Birth	State of Health	Age at Death	Cause of Death	Check if any of you blood relatives had any of the following:	
						Disease	Relationship to You
Father						<input type="checkbox"/> Adrenal Disorder	
Mother						<input type="checkbox"/> Calcium Disorders / Kidney Stones	
Brothers						<input type="checkbox"/> Cancer	
						<input type="checkbox"/> Diabetes	
						<input type="checkbox"/> Heart Disease, Strokes	
						<input type="checkbox"/> High Blood Pressure	
Sisters						<input type="checkbox"/> Osteoporosis	
						<input type="checkbox"/> Pituitary Disorders	
						<input type="checkbox"/> Thyroid Disorders	
						<input type="checkbox"/> Cholesterol / Lipids	
Children total # of children _____						<input type="checkbox"/> Psychiatric Disorders	
						<input type="checkbox"/> Other	

HOSPITALIZATIONS / SURGICAL PROCEDURES			PREGNANCY HISTORY		
Year	Facility	Procedures, Reason and Outcome	Year of birth	Sex of birth	Complications if any

SERIOUS ILLNESSES/ INJURIES		DATE	OUTCOME	HEALTH HABITS For each substance below. Describe how much you use below as: Never, Prior, Current	
				<input type="checkbox"/> Caffeine	
				<input type="checkbox"/> Tobacco	
				<input type="checkbox"/> Recreational Drugs	
				<input type="checkbox"/> Alcohol	
				OCCUPATION:	

To the best of my knowledge the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

_____	_____
Signature of Patient, Parent, Guardian or Personal Representative	Date
_____	_____
Print Name of Patient, Parent, Guardian or Personal Representative	Relationship to Patient