Endocrine and Diabetes Associates, LLC

PATIENT INFORMATION	Patient Name:	SSN:	DOB: / /	Sex:	Marital Status:

***Race:**

- ❑ American Indian or Alaska Native
- ❑ Asian
- ❑ Black or African American
- ❑ White
- ❑ Native Hawaiian
- ❑ Other Pacific Islander
- ❑ Other
- ❑ Prefer not to specify

***Ethnicity:**

- ❑ Hispanic
- ❑ Non-Hispanic
- ❑ Prefer not to specify

***Preferred Language:**

Street Address	Home #	Cell #
City, State, Zip	Preferred method of contact: ❑ Cellphone / SMS (text) ❑ 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:

_____ **Date:** _____

Signature of Patient or Legal Guardian

Endocrine and Diabetes Associates, LLC

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Beatriz H. Chanduvi, MD FACE
Archana Shetty, MD
Anurag Gupta, MD
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request@endocrinemd.net

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.

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

MEDICATIONS List medications you are currently taking.

_____

_____

_____

_____

_____

Pharmacy Name _____

Phone number _____

ALLERGIES To medications or substances.

_____

_____

_____

_____

_____

_____

❑ None

See back portion ⇩

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						❑ Adrenal Disorder	
Mother						❑ Calcium Disorders / Kidney Stones	
Brothers						❑ Cancer	
						❑ Diabetes	
						❑ Heart Disease, Strokes	
						❑ High Blood Pressure	
Sisters						❑ Osteoporosis	
						❑ Pituitary Disorders	
						❑ Thyroid Disorders	
						❑ Cholesterol / Lipids	
Children total # of children _____						❑ Psychiatric Disorders	
						❑ Other	

HOSPITALIZATIONS / SURGICAL PROCEDURES

Year	Facility	Procedures, Reason and Outcome

PREGNANCY HISTORY

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

❑ Caffeine	
❑ Tobacco	
❑ Recreational Drugs	
❑ 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**