

Endocrine and Diabetes Associates, LLC Drs. Petrick, Liu, Chanduvi, Shetty, Gupta, Almecci and Rogstad

PATIENT INFORMATION	Patient Name:	SSN:	DOB: / /	Sex:	Marital Status:
	Race:		Ethnicity:		Preferred Language:
<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	<input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic	
Street Address		Home #	Work#	Ext:	
City, State, Zip		Fax#	Cell#		
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	
<p>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 new patient appointments missed without 24 hours' notice. This fee is \$50 for missed follow up appointments. 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.</p> <p>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.</p> <p>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.</p>					
I Agree To The Above Stated Responsibility and Consent:					
Signature of Patient or Legal Guardian					Date:

Endocrine and Diabetes Associates, LLC

Patricia A Petrick, MD FACP
Linda Liu, MD FACP
Beatriz H. Chanduvi, MD FACE
Archana Shetty, MD
Anurag Gupta, MD
Yemul Almecci, MD
Amy Rogstad, MD

6430 Rockledge Drive, Suite 300
Bethesda, Maryland 20817
Phone 301-468-1451
Fax 301-468-3580

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	GASTROINTESTINAL	EYE, EAR, NOSE, THROAT	WOMEN only
<input type="checkbox"/> Chills	<input type="checkbox"/> Appetite poor	<input type="checkbox"/> Blurred vision	<input type="checkbox"/> Abnormal Pap Smear
<input type="checkbox"/> Depression	<input type="checkbox"/> Bloating	<input type="checkbox"/> Difficulty swallowing	<input type="checkbox"/> Bleeding between periods
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Bowel changes	<input type="checkbox"/> Double vision	<input type="checkbox"/> Breast lump or tenderness
<input type="checkbox"/> Fainting	<input type="checkbox"/> Constipation	<input type="checkbox"/> Earache	<input type="checkbox"/> Hot Flashes
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Hoarseness	<input type="checkbox"/> Painful intercourse
<input type="checkbox"/> Fever	<input type="checkbox"/> Excessive hunger	<input type="checkbox"/> Loss of hearing	<input type="checkbox"/> Poor libido
<input type="checkbox"/> Forgetfulness	<input type="checkbox"/> Excessive thirst	<input type="checkbox"/> Persistent cough	<input type="checkbox"/> Nipple Discharge
<input type="checkbox"/> Headache	<input type="checkbox"/> Gas		<input type="checkbox"/> Vaginal Discharge
<input type="checkbox"/> High/low blood sugar	<input type="checkbox"/> Indigestion / Reflux		<input type="checkbox"/> Other _____
<input type="checkbox"/> Loss of sleep / poor sleep	<input type="checkbox"/> Nausea	SKIN	Date of Last Menstrual Period _____
<input type="checkbox"/> Nervousness	<input type="checkbox"/> Rectal bleeding	<input type="checkbox"/> Hives	Date of Last PAP Smear _____
<input type="checkbox"/> Numbness	<input type="checkbox"/> Stomach pain	<input type="checkbox"/> Itching	When was your last mammogram? _____
<input type="checkbox"/> Sensitivity to cold or heat	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Rash	Are you Pregnant? _____
<input type="checkbox"/> Sweats		<input type="checkbox"/> Sore that won't heal	
<input type="checkbox"/> Tremors	CARDIOVASCULAR	MEN only	
<input type="checkbox"/> Weight loss / gain	<input type="checkbox"/> Chest pain	<input type="checkbox"/> Breast enlargement	
GENITO-URINARY	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Breast lump	
<input type="checkbox"/> Blood in urine	<input type="checkbox"/> Irregular heart beat	<input type="checkbox"/> Erection difficulties	
<input type="checkbox"/> Frequent urination	<input type="checkbox"/> Low blood pressure	<input type="checkbox"/> Lump in testicles	
<input type="checkbox"/> Lack of bladder control	<input type="checkbox"/> Rapid heart beat	<input type="checkbox"/> Penis discharge	
<input type="checkbox"/> Painful Urination	<input type="checkbox"/> Swelling of ankles	<input type="checkbox"/> Poor libido	
<input type="checkbox"/> Urination at night	<input type="checkbox"/> Varicose veins	<input type="checkbox"/> Sore on penis	
		<input type="checkbox"/> Other _____	

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

