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

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

Preferred Language:

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

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.

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

Updated 4/29/19

Endocrine & Diabetes Associates

NEW PATIENT QUESTIONNAIRE

Printed Patient Name:_____ **Date of Birth:** _____
REASON FOR VISIT: _____ **Today's Date:** _____
Referring Physician: _____
Preferred Pharmacy:_____

Please bring all relevant X-rays, CAT scans (disc or film) as well as other diagnostic reports to your first visit.

MEDICAL HISTORY: (Mark All that Apply)

Thyroid	**Diabetes**
Hypothyroidism (underactive Thyroid)	Age at Diagnosis:
Hyperthyroidism (overactive Thyroid)	Symptoms at Diagnosis:
Thyroid Nodule – Date Diagnosed:	Date started Medication:
Thyroid Cancer – Date Diagnosed:	Date started Insulin:
Heart	Retinopathy
High Blood Pressure	Date of Last Eye Exam
High Cholesterol	Laser Therapy
Heart Attack	Neuropathy
Heart Failure	Increased Urinary Protein
Angioplasty / Stent	**Cancer**
Atrial Fibrillation / Flutter	No Yes Type:
Stroke	**Neuro / Psychiatric**
Lung	Seizures
Asthma	Neuropathy
COPD / Emphysema	Stroke
Sleep Apnea	Migraine
Other:	Eating Disorder
Bone	Alcoholism
Osteopenia	Addiction
Osteoporosis	Depression
Hip Fracture	Anxiety
Spine Fracture	Other:
Wrist Fracture	**GYN**
GI	Date of First Period Regular Irregular
Hepatitis	How Many Pregnancies
Celiac Disease	Last Period
GERD/Reflux	Hormone Replacement
Gallstones	**Other Medical Conditions**
Other:	1.
Kidney Disease	2.
Abnormal Kidney Function	3.
Dialysis	4.
Kidney Transplant	5.
Kidney Stones	6.

SURGICAL HISTORY: (Mark All that Apply and Indicate Date Performed)

Heart Bypass	Gallbladder
Angioplasty/Stent	Thyroid Surgery
Leg Bypass	Pituitary Surgery
Hip Replacement	Other Surgeries:
Hysterectomy	1.
Ovaries Removed: yes no	2.
	3.

CURRENT MEDICATIONS :

NAME	DOSE	FREQUENCY	INDICATION

MEDICATION ALLERGIES: ☐ **No Known Allergies** If yes, complete below:

Drug Name	Reaction

SOCIAL HISTORY:

Marital Status: _____ Children: ___ Girls _____ Boys

Occupation: _____

Smoking: Current Maximum packs/day_____

Former Number of years smoked _____ Year quit _____

Never

Alcohol: _____ Drinks per week

Caffeine: _____ per day

Exercise type and frequency: _____

Special Diet / Type / Restrictions: _____

Patient Name: _____ **Date of Birth:** _____

FAMILY HISTORY: (Mark All that Apply and List Family Member)

	Family Member			Family Member
Diabetes:			Thyroid Nodule	
Adult Onset/Type II			Goiter	
Juvenile Onset/Type I			Thyroid Cancer	
High Blood Pressure			Calcium Disorder	
High Cholesterol			Parathyroid Disease	
Heart Attack			Osteoporosis	
Stroke			Hip Fracture	
Hypothyroid/Underactive			Kidney Stones	
Hyperthyroid/Overactive			Adrenal Disease	
Cancer			Pituitary Disease	
Other:			Other:	

REVIEW OF SYMPTOMS: (Mark All that Apply)

General	Cardiovascular	Genitourinary
Weight Gain	Chest Pain	Pain with Urination
lbs. in months/yrs.	Heart Attack	Frequent Urination
Weight Loss	Heart Murmur	Blood in Urine
lbs. in months/years	Palpitations	Urinating Overnight
Sleeping Problems	Irregular Heart Beat	Number of times per night
Fatigue	Shortness of Breath w/Walking	Hesitation with Urination
Fevers/Chills/Sweats	Dizziness	Incomplete Voiding
Skin	Swelling of Feet/Ankles	Lack of Bladder Control
Skin Rash	**Gastrointestinal**	**Men:**
Itching	Nausea / Vomiting	Erectile Dysfunction
New Skin Marks/Spots	Vomiting Blood	Changes in libido
Head/Eyes/Ears/Nose/Throat	Difficulty Swallowing	Fertility problems
Visual Problems / Changes	Heartburn/Indigestion	Pain or changes in Penis/Testicles
Type:	Abdominal Pain	Testicular Mass / Breast Lump
	Constipation / Diarrhea	**Women:**
Voice Changes	Reflux / Bloating	Premenopausal
Sinus Infections	**Neurological / Psychiatric**	Perimenopausal
Hoarseness	Headache / Light-headedness	Postmenopausal
Sore Throats	Numbness / Tingling	Irregular Periods
Headaches	Dizziness / Vertigo / Fainting	Fertility Problems
Respiratory	Balance Problems / Falling	Prior Pregnancy
Coughing	Changes in Mood	Prior Miscarriage/Abortion
Wheezing	Concentration/Memory changes	Nipple Discharge
Shortness of Breath	Anxiety / Depression	Hot Flashes
Bone / Muscle	**Endocrine**	**Endocrine (Continued)**
Joint Pain	Excessive Thirst	Feeling of lump in neck
Muscle Pain	Excessive Urination	Tremor
Bone Pain	Intolerance to heat/cold	Low Blood Sugar Reaction
Back Pain	Changes to Skin/Hair/Nail	Frequency:
Other:	Describe:	Other:

Patient Signature: _____ **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**