

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

<b>PATIENT INFORMATION</b>		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		Preferred Language:
Street Address		Home #		Work#	Ext:	
City, State, Zip		Fax#		Cell#		
Employer						
Primary Care Physician		Referring Physician		Personal email:		
<b>PHARMACY NAME &amp; PHONE NUMBER (LOCAL and/or MAIL ORDER)</b>						
<b>FINANCIALLY RESPONSIBLE PARTY (IF MINOR OR DEPENDENT)</b>						
Guarantors Last Name:		First Name		MI	Work#	
Street Address		City, State, Zip			Home#	
Employer		Employer Address				
<b>PRIMARY INSURANCE INFORMATION</b>						
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	
<b>SECONDARY INSURANCE INFORMATION</b>						
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	
<b>EMERGENCY CONTACT</b>						
Name			Phone		Relationship	
<p><b>1. FINANCIAL RESPONSIBILITY</b>          I certify that the information I have provided regarding my insurance coverage is correct and authorize Endocrine &amp; 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 &amp; 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 same day cancellation or missed appointments 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.</p> <p><b>2. RELEASE OF MEDICAL INFORMATION</b>          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><b>3. NON-COVERED SERVICES</b>          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>						
<b>I Agree To The Above Stated Responsibility and Consent:</b>						
Signature of Patient or Legal Guardian			Date: _____			

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)**

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

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**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
<b>Skin</b>	Swelling of Feet/Ankles	Lack of Bladder Control
Skin Rash	<b>Gastrointestinal</b>	<b>Men:</b>
Itching	Nausea / Vomiting	Erectile Dysfunction
New Skin Marks/Spots	Vomiting Blood	Changes in libido
<b>Head/Eyes/Ears/Nose/Throat</b>	Difficulty Swallowing	Fertility problems
Visual Problems / Changes	Heartburn/Indigestion	Pain or changes in Penis/Testicles
Type:	Abdominal Pain	Testicular Mass / Breast Lump
	Constipation / Diarrhea	<b>Women:</b>
Voice Changes	Reflux / Bloating	Premenopausal
Sinus Infections	<b>Neurological / Psychiatric</b>	Perimenopausal
Hoarseness	Headache / Light-headedness	Postmenopausal
Sore Throats	Numbness / Tingling	Irregular Periods
Headaches	Dizziness / Vertigo / Fainting	Fertility Problems
<b>Respiratory</b>	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
<b>Bone / Muscle</b>	<b>Endocrine</b>	<b>Endocrine (Continued)</b>
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