PATIENT REGISTRATION FORM

Name: _____ Age: _____ DOB: _____ Sex: Male/Female
Address: _____ City: _____ Zip Code: _____
Telephone: (HOME) _____ (CELL) _____ (WORK) _____
Social Security Number: _____ Email: _____

Language: ☐ English ☐ Spanish ☐ Other: _____

Race: ☐ Asian ☐ Hispanic or Latino
☐ American Indian Or Alaskan Native ☐ Hawaiian Native/ Pacific Islander
☐ Black/African American ☐ White
☐ Other Race

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed
Employment Status: ☐ Full ☐ Part Time ☐ Retired ☐ Not Employed ☐ Student
Employer: _____

Pharmacy: _____ Phone Number: _____
Address: _____ City: _____

INSURANCE INFORMATION

PRIMARY INSURANCE: _____
Insurance ID No: _____
Group No: _____
Responsible Party: Self Others
Relationship to Insured: _____
Subscriber name: _____
Subscriber DOB: _____
Subscriber Address: _____

SECONDARY INSURANCE: _____
Insurance ID No: _____
Group No: _____
Responsible Party: Self Others
Relationship to Insured: _____
Subscriber name: _____
Subscriber DOB: _____
Subscriber Address: _____

Primary Care Physician

Name: _____
Address: _____
Telephone: _____
Fax: _____

Referring Physician

Name: _____
Address: _____
Telephone: _____
Fax: _____

Other physicians involved in your care (cardiologist, neurologist, pulmonologist, etc.)

1. Name: _____ Specialty: _____ Phone Number: _____
   Address: _____
2. Name: _____ Specialty: _____ Phone Number: _____
   Address: _____
3. Name: _____ Specialty: _____ Phone Number: _____
   Address: _____

AUTHORIZED CONTACT PERSON in case of Emergency or to discuss your Medical condition
Name: _____ Relationship: _____ Phone number: _____

I VERIFY THE ACCURACY OF THE ABOVE INFORMATION
Patient or AUTHORIZED SIGNITURE _____ Date: _____

PLEASE READ THE FOLLOWING CAREFULLY:

1. ASSIGNMENT OF BENEFIT PROCEEDS & INDIVIDUAL'S RESPONSIBILTY FOR NON-COVERED SERVICES

I request that payment of authorized HMO/third-party payer/governmental agencies (Medicare and Medicaid) benefits be made either to me or on my behalf to Endocrinology, Diabetes & Metabolism, NY P.C. for services furnished to me by the provider. **The undersigned promise(s) to pay Endocrinology, Diabetes & Metabolism, NY P.C. any co-payment, coinsurance or other that are not covered by health care insurance.**

_____ _____
Date Initial **Medicare**

Patients: Upon receipt of the Medicare Explanation of Benefits, we will bill you the difference between what Medicare has paid us and the amount Medicare legally allows us to charge you. We will bill your secondary insurance, if you have one. ACCEPTED ASSIGNMENT DOES NOT EXEMPT YOU FROM PAYMENT OF THE BALANCE DUE.

( ) I understand that this request is not restricted.

( ) Release is restricted to treatment as of_____/_____/_____(Date of Restriction) _____ _____
Date Initial

2. CO-PAYMENTS/REFERRALS/SELF-PAY

CO-PAYMENTS ARE DUE AT THE TIME OF VISIT. If benefits are denied, *you will be billed according to the regular fee schedule.*

HMO PLANS (CIGNA/HIP, BCBS, UNITED, etc.): For plans requiring referrals from the primary care physician, AUTHORIZATION MUST BE OBTAINED PRIOR TO THE TIME OF THE VISIT. *Unauthorized visits will be billed to you according to the regular fee schedule.*

SELF-PAY: PAYMENT IS EXPECTED AT THE TIME OF VISIT _____ _____
Date Initial

3. POLICY FOR "NO-SHOW" APPOINTMENTS

I understand that I am financially responsible for a charge of **$20.00** to any and all appointments missed in which a 24 hour notice of cancellation has not been given.

_____ _____
Date Initial

4. PRIVACY NOTICE ACKNOWLEDGEMENT

I acknowledge that I have been provided with a copy (on website) of Practice Privacy regulations (HIPAA).

_____ _____
Date Initial

5. AUTHORIZATION TO RELEASE RECORDS:

I hereby authorize Endocrinology, Diabetes & Metabolism, NY P.C.to release to my insurer/HMO/third-party payer, governmental agencies, or to whomever is financially responsible for my medical care, all information needed to substantiate payment for such medical care and, if required, for precertification/prior approval purposes.

( ) I understand that this request is not restricted.

( ) Release is restricted to treatment as of_____/_____/_____(Date of Restriction) _____ _____
Date Initial

6. CHRONIC CARE MANAGEMENT (Medicare patients)

I agree to participate in chronic care management through services rendered by Endocrinology, Diabetes & Metabolism, NY P.C., whereby I will have telephone evaluation (non-face to face) with the office practitioners. The visit will be charged under my insurance plan and I will be responsible for an **$8.00 fee/month of service.**

_____ _____
Date Initial

I have reviewed the above notice of the practice's financial policies and procedures.

_____ _____
Date Signature of Patient/Guarantor/Authorized Representative

PERSONAL QUESTIONAIRE

Name_____

A. Reason for Visit _____

_____

_____

B. Family History

	Medical Problems	Alive	Deceased-Cause of Death
Maternal Grandfather	_____	_____	_____
Maternal Grandmother	_____	_____	_____
Paternal Grandfather	_____	_____	_____
Paternal Grandmother	_____	_____	_____
Mother	_____	_____	_____
Father	_____	_____	_____
Children	_____	_____	_____
Spouse/Partner	_____	_____	_____

C. Illness: If you have any of the following, please mark with a check

_____Alcoholism	_____Kidney Disease	_____Cancer/Tumor
_____Anemia	_____Lung Disease	_____High Blood Pressure
_____Arthritis	_____Osteoporosis	_____Stomach Ulcer
_____Bleeding Disorder	_____Epilepsy	_____High Cholesterol
_____Diabetes	_____Glaucoma	_____Drug Abuse
_____Heart Disease	_____Stroke	_____Depression
_____Eye Disease	_____Eczema/Rashes	_____Phlebitis
_____Liver Disease	_____Thyroid Disease	_____Kidney Stones

D. Medication Name/Dose/Frequency

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

E. Hospitalizations/Surgeries

Year	Reason
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

F. Drug Allergies _____

Name:_____ Date: _____

REVIEW OF SYSTEMS: Place a check mark next to any symptoms you have been experiencing from the following list:

GENERAL/CONSTITUTIONAL
- Fatigue ___
- Sleep Disturbance ___

EYES
- Headaches ___
- Blurred vision ___
- Failing vision ___
- Eye pain ___
- Double vision ___
- Dry eyes ___
- Bulging eyes ___

HEAD AND NECK
- Difficulty swallowing ___
- Dry mouth ___
- Change of taste ___
- Swollen glands/neck ___
- Decreased hearing ___
- Facial pain ___
- Congestion ___
- Frequent colds/infections ___
- Prolonged hoarseness ___
- Persistent neck rigidity ___
- Chronic sore tongue ___

ENDOCRINE
- Cold/heat intolerance ___
- Excessive sweating ___
- Excessive thirst ___
- Weight change ___
- Irregular menses ___

RESPIRATORY
- Chronic cough ___
- Shortness of breath at rest ___
- Shortness of breath with exertion ___
- Night sweats _____

CARDIOVASCULAR
- Chest pain at rest ___
- Chest pain with exertion ___
- Leg swelling ___
- Skipping/irregular heart beats ___
- Palpitations ___

GASTROINTESTINAL
- Abdominal pain ___
- Nausea ___
- Vomiting ___
- Heartburn ___
- Constipation ___
- Diarrhea ___
- Black, tarry stool ___
- Rectal bleeding ___
- Loss of appetite ___

HEMATOLOGY
- Easy bruising ___
- Prolonged bleeding ___

GENITOURINARY
- Frequent urination ___
- Frequent night urination ___
- Painful urination ___
- Blood in urine ___
- Hard to start urinary flow ___
- Loss of bowel/bladder control ___
- Urinary retention ___

MUSCULOSKELETAL
- Physically handicapped/limited ___
- Joint stiffness ___
- Leg cramps ___
- Joint pain ___
- Swollen joints ___
- Neck/back/shoulder pain ___
- Any tingling/numbness ___
- Disturbance in walking ___
- Muscle jerking ___
- Paralysis ___
- Shaking ___
- Decreased sensation in extremities ___
- Foot ulcer ___

SKIN
- Dry skin ___
- Rash ___
- Acne ___

NEUROLOGIC
- Difficulty balancing ___
- Dizziness ___
- Fainting ___
- Memory loss ___
- Speech changes ___

PSYCHIATRIC
- Anxiety ___
- Depressed mood ___
- Suicidal thoughts ___

FOR WOMEN:

Last menstrual period:

_____

Typical cycle is_____days in length.

Menstrual period lasts_____days.

Birth control: _____

Last PAP smear:_____

Last Mammogram: _____