ENDOCRINOLOGY & DIABETES CENTER - PATIENT REGISTRATION

Name: ______________________________ **Date of Birth:** ______________________________

Address: ______________________________ **City, State:** ______________________________
Zip: ______________________________

Home Phone: ______________________________ **Work Phone:** ______________________________
Cell Phone: ______________________________

SSN: ______________________________ **Marital Status:** ______________________________

Referring Dr. ______________________________
Address: ______________________________
PCP: ______________________________
Address: ______________________________

Pharmacy Name: ______________________________ **Pharmacy Address:** ______________________________

Emergency Contact Name and Phone Number: ______________________________

Email Address (needed for patient portal access): ______________________________

Guarantor Name (if patient under age 18): ______________________________

INSURANCE INFORMATION

Primary Insurance Company: ______________________________
Policy ID Number: ______________________________ Group Number: ______________________________
Subscriber's Name: ______________________________ Subscriber's DOB: ______________________________

Secondary Insurance Company: ______________________________
Policy ID Number: ______________________________ Group Number: ______________________________
Subscriber's Name: ______________________________ Subscriber's DOB: ______________________________

I hereby authorize direct payment of medical benefits to Endocrinology & Diabetes Center (EDC) for services rendered by a physician or nurse practitioner in person or under his/her supervision. I understand that I am financially responsible for any balance allowed, but not paid, by my **in-network** insurance company. I also understand that if I utilize any **out-of-network** services, there may be reduced benefits and I may be required to pay a larger co-pay, co-insurance or other charge. **I agree to pay all required copays and /or coinsurances at time of service and that all required referrals are my responsibility to acquire and bring with me.** I understand that if my account becomes delinquent and collection becomes necessary, the undersigned agrees to be responsible for attorney's fees of 33 1/3%, interest at 18% per annum from the last date of payment and any and all applicable court costs. I also understand that in the event that a check is returned by my bank for any reason, I will be assessed a $30.00 returned check fee. Furthermore, if not paid within 10 days from the date of notice, EDC will submit this delinquent account over to our attorney at which time any and all civil penalties as provided in Section 8.01-27.1 of the code of Virginia (1950) will be imposed.

I hereby authorize EDC to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefit, as allowed by law. I certify that the information given by me in applying for payment is correct. I request that payment of authorized benefits be made on my behalf. A photocopy of these assignments shall be valid as the original.

Patient (or Parent if patient under age 18)
Signature: ______________________________ Date: ______________

ENDOCRINOLOGY & DIABETES CENTER

PATIENT HEALTH HISTORY

NAME: ______________________________ TODAY'S DATE: ______________

AGE: ______ DATE OF BIRTH: ____________ ALLERGIES: ____________________

SYMPTOMS: Circle symptoms you currently have or have had in the past year.

GENERAL

Chills
Depression
Dizziness
Fainting
Fever
Forgetfulness
Headache
Loss of Sleep
Loss of Weight
Nervousness
Numbness
Sweats

PAIN, WEAKNESS, OR NUMBNESS IN:

Arms Legs
Back Hips
Feet Neck
Hands Shoulders

GENITO-URINARY

Blood in urine
Frequent urination
Lack of bladder control
Painful urination
Difficultly in urination
Weak stream

GASTROINTESTINAL

Poor appetite
Bloating
Bowel changes
Constipation
Diarrhea
Excessive hunger
Excessive thirst
Gas
Hemorrhoids
Indigestion
Nausea
Rectal bleeding
Stomach pain
Vomiting
Vomiting Blood

CARDIOVASCULAR

Chest pain
High blood pressure
Irregular heart beat
Low blood pressure
Poor circulation
Rapid heart beat
Swelling of ankles
Varicose veins

EYES, EARS, NOSE,THROAT

Bleeding gums
Blurred vision
Crossed eyes
Difficultly swallowing
Double vision
Earache
Ear discharge
Hay fever
Hoarseness
Loss of hearing
Nosebleeds
Persistant cough
Ringing in ears
Sinus problems
Vision - flashes
Vision - halos

SKIN

Bruise easily
Hives
Itching
Change in moles
Rash
Scars
Sore that won't heal

MEN ONLY

Breast lump
Erection difficulties
Lump in testicles
Penis discharge
Sore on penis
Other

WOMEN ONLY

Abnormal PAP smear
Bleeding between periods
Breast lumps
Extreme menstrual pain
Hot flashes
Nipple discharge
Painful intercourse
Vaginal discharge
Other

DATE OF LAST:

Pap: ______________
Period: ______________
Mammogram: __________
Are you pregnant? _______
Number of children: ______

CONDITIONS: Circle conditions you currently have or have had in the past.

AIDS
Alcoholism
Anemia
Anorexia
Appendecitis
Arthritis
Asthma
Bleeding disorders
Breast lumps
Bronchitis
Bulemia
Cancer
Cataracts

Chemical dependency
Chicken pox
Diabetes
Emphysema
Epilepsy
Glaucoma
Goiter
Gonorrhea
Gout
Heart disease
Hepatitis
Hernia
Herpes

High cholesterol
HIV positive
Kidney disease
Liver Disease
Measles
Migraine headaches
Miscarriage
Mononucleosis
Multiple sclerosis
Mumps
Pacemaker
Pneumonia
Polio

Prostate problems
Psychiatric care
Rheumatic fever
Scarlet fever
Stroke
Suicide attempt
Thyroid problems
Tonsilitis
Tuberculosis
Thyphoid Fever
Ulcers
Vaginal Infections
Venereal disease

FAMILY HISTORY: Fill in health information about your family:

RELATIONSHIP	AGE	STILL LIVING (y/n)	IF DECEASED, AGE AT DEATH?	CAUSE OF DEATH
Mother				
Father				
Sisters				
Brothers				

Check if any blood relation above has had any of the following conditions. Please note relationship.

DISEASE	RELATIONSHIP #1	RELATIONSHIP #2	RELATIONSHIP #3
Arthritis			
Asthma			
Cancer			
Diabetes			
Heart Disease			
Hypertension			
Kidney Disease			
Osteoporosis			
Thyroid Disease			
Tuberculosis			

CURRENT MEDICATIONS
(Must be written below)

NAME OF MEDICATION	DOSAGE	NUMBER OF TIMES PER DAY

ENDOCRINOLOGY & DIABETES CENTER

SURGICAL HISTORY / RECENT HOSPITALIZATIONS:

SURGICAL PROCEDURE / REASON FOR HOSPITALIZATION	DATE	HOSPITAL

ALLERGIES:

TYPE (Food, Medication, Other)	NAME OF MEDICATION OR FOOD	REACTION OR SIDE EFFECT

HIPAA:

- ☐ I acknowledge that I have been provided an opportunity to review the Notice of Privacy Practices and that, upon request, I can receive a copy of said Notice. I authorize the following person(s) to have access to my medical information.

_______________________ _______________________

_______________________ _______________________

ELECTRONIC PRESCRIPTIONS:

- ☐ I authorize Endocrinology and Diabetes Center to electronically review and download my prescription history, and to electronically send prescriptions to my pharmacy.

_______________________ _______________________ _______________

Signature | Print Name | Date

ENDOCRINOLOGY & DIABETES CENTER
DIABETES CARE RECORD
(Complete Only If Being Seen For Diabetes)

Name: ______________________________ **Date of Birth:** ________________

Age Diabetes was Diagnosed: __________ **How long have you had Diabetes:** __________

Present Treatment (circle): Diet Exercise Pills Insulin Other ______________

Diabetes Complications:
(circle all that apply)

Eyes: Laser Treatments – Yes or No
Last Dilated Eye Exam: ______________

Kidneys: Dialysis - Yes or No
Kidney Specialist: ________________

Neuropathy: Hands______ Feet ________ Legs ________
(tingling/numbness/burning)

Erectile Difficulties or
Problems with Sexual Dysfunction: Yes or No

Dental Problems: Yes or N
Last Dental Exam: ______________

Foot Problems: Yes or No
Last Podiatry Exam: ____________

Frequent Infections: Vaginal Feet Gums Skin

Other Complications of Diabetes: ______________________________________

Do you check your Blood Sugar?: Yes or No **How Often?:** ________________

Name of Glucose Meter: ____

How Often Do You Have Low Blood Sugar?: ________________________________

How do you treat it?: ____

Exercise: Yes or No **How often?:** Daily 2-3 days per week 4-5 days per week

Do You Smoke or chew tobacco?: Yes or No **How long?:** _______ **How Much?:** _______

Do You Drink Alcohol?: Yes or No **How Often?:** Occasionally Monthly Weekly Daily

When was the last Diabetes Education Class you attended?: ____________________
Where: ____