My Endocrinologist
213 S. Dillard St., Suite 240
Winter Garden, Fl 34787
Ph: 407.409.8067 Fax: 407.409.8068
myendocrinologistmd@gmail.com

Patient History

Name:_____Date of birth:_____
What is the main reason for your visit? _____
How did you hear about us? _____
Primary Doctor:_____Pho:_____ Fax: _____
Allergies(Medication and reaction): _____
Marital Status: Single__Married__Divorced__Widowed__Separated_
How many children:_____
Occupation:_____
Do you smoke? Yes___No__If yes, how many packs per day?_____For how long?_____
If you have quit, how long ago?_____
Do you use alcohol? Yes__No__ If yes, how often do you drink?_____
If you have quit, how long ago?_____
Have you ever had problems with drug use?_____
Do you exercise?_____ _____minutes per day _____times per week
Number of pregnancies:___C-sections:___How many children have you had?:____
Last menstrual period:_____Last PAP _____

TEST: Please list last year this test was done and results (normal or abnormal)
Mammogram:___/___/___Result:_____
DEXA Bone density:___/___/___Result:_____
Dental Exam:___/___/___Result:_____
Thyroid Ultrasound:___/___/___Result:_____
Flu vaccine: ___/___/___ Any Reaction? Yes __No __
Pneumonia vaccine: ___/___/___ Any reaction? Yes __No _
Do you take daily aspirin? Yes___No___Side effects _____
How many days supply do you get your meds? 30 days___90 days _

PLEASE COMPLETE THE FOLLOWING SECTION ONLY IF YOU HAVE <u>DIABETES</u>
When were you diagnosed with diabetes?_____
Last eye exam: ___/___/___
Has diabetes affect your eyes?Yes___No___Eye laser therapy? Yes___No _
Last foot exam: ___/___/___
Do you have neuropathy? Yes___No___Don't know_
Had you have nerve conduction studies? Yes __No __Results:_____
Kidney problems? Yes___No___Don't know
Protein in urine? Yes___No___Don't know_
Do you have circulation problems? Yes___No___Don't know_
Do you know your last A1c? Yes___Value_____No___Don't know
Have you gone to a diabetes education class? Yes___No___Don't know
Do you follow your diet? Yes___No___Try_
Do you check your glucose at home? Yes___Frequency_____No _
Do you have low glucose reactions? Yes___Frequency_____No _
What glucose meter do you use?_____

Signature:_____ Date:_____

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Personal History	Self	Family	Relationship	Age of onset
Diabetes				
High blood pressure				
Thyroid condition				
Congestive heart failure				
Other heart condition				
High cholesterol				
Liver disease				
Kidney problems				
Pancreatic condition				
Lung condition				
Cancer				
Other (Specify)				

Medication list: **currently being used (include non prescription medication)**

Medication	Dose	Frequency

Signature:_____ Date:_____

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Condition	Yes	No
GENERAL		
Loss of appetite		
Weight loss		
Weight gain		
Fatigue		
Insomnia		
General weakness		
Other:		
ENDOCRINE		
Excessive thirst		
Sensibility to cold Temp.		
Sensibility to hot Temp.		
Excessive urination		
Hot flashes		
Other:		
EYES		
Vision loss		
Decreased vision		
Double vision		
Bulging eyes		
Other:		
ENT		
Hearing problems		
Dizziness		
Change in voice/hoarseness		
Difficulty swallowing		
Other:		
NECK		
Lump		
Swelling		
Pain		
Other:		

Condition	Yes	No
CARDIOVASCULAR		
Chest pain		
Palpitations		
Low tolerance to exercise		
RESPIRATORY		
Shortness of breath		
Cough		
Wheezing		
GASTROINTESTINAL		
Heartburn		
Nausea		
Vomiting		
Abdominal pain		
Diarrhea		
Constipation		
URINARY		
Blood in urine		
Urination at night		
Problems passing urine		
EXTREMITIES		
Swelling of the legs		
Decrease sensibility		
Numbness		
Tingling		
Cramps in legs		
Pain in legs when walking		
MUSCULOSKELETAL		
Joint pain		
Back pain		
Muscle strength loss		

Condition	Yes	No
NEUROLOGIC		
Weakness/Paralysis		
Difficulty walking		
Memory loss		
Tremor		
PSYCHIATRIC		
Depression		
High stress levels		
Mood changes		
Sleep disturbances		
SKIN		
Rash		
Skin ulcer		
Bruise easily		
Excessive hair growth		
Hair loss		
GENITAL (MALE)		
Breast lump		
Erectile dysfunction		
GENITAL (FEMALE)		
Breast discharge		
Breast lump		
Sexual dysfunction		
Changes in period		
Last menstrual period:		

Signature:_____ Date:_____

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Name:_____Date of birth:_____

Address:_____City:_____State:_____Zip:

Home phone: _____Cell phone:_____

Work phone: _____Email:_____

Preferred method of communication: Email____Phone____Mail___

S.S:_____Marital status:_____Gender: M or F

Occupation: _____Employer: _____

****

Ethnicity: Non-Hispanic___Hispanic___Not specified___

Race: African o African American___Caucasian__Native Hawaiian_

Asian o Asian American__Native American__Other: _____

****

Preferred pharmacy:_____Pharmacy phone number:_____
Address: _____

****

Primary insurance:_____Member ID: _____

Group #:_____Effective day: _____

Primary insurance's name: _____DOB:_Gender: M or F

S.S:_____Phone:_____Relationship:_____

Address:_____City:_____State:____Zip:_____

****

Secondary insurance:_____Member ID: _____

Group #:_____Effective day: _____

****

Emergency contact: _____Relationship:_____
Address:_____City:_____State:____Zip:_____

Phone number: _____

****

We are participants with medicare. if you have a supplemental insurance that crosses over from medicare and pays the doctor, then we will not collect the 20%. If it does not cross over or you have no secondary insurance, then we will collect 20% plus deductible at the time or service. Payment is expected at the time service is rendered unless prior financial agreement have been made prior to your appointment. An insurance receipt will be given to you to send to your insurance company. This office will file for procedure and hospitalization.

I guarantee my endocrinologist PA payment for all charges for the above named patient in accordance with their regulations and charges. In the event that my endocrinologist PA chooses to bill my insurance company I hereby authorize my insurance company to pay directly to them all medical benefits due for me under this policy. If the services are not covered by medicare or other insurance. I understand that I will be responsible for payment, I also understand and agree that any outstanding bills will be my responsibility.

I authorize the release of any medical or other information necessary to process my claims to medicare or any other insurance of whom I am beneficiary, also authorize the release of any medical records from an outside facility that may be requested to the office.

General Consent for Treatment We appreciate you entrusting you or a family member health care to our practice. However, we need your permission for our clinicians to examine you, provide treatments, and perform diagnostic studies as necessary. If more invasive procedures are deemed necessary, the risks and benefits of those invasive treatments will be explained to you. I give general consent to be treated by Practitioner at My Endocrinologist PA

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AUTHORIZATION TO OBTAIN, RELEASE, OR REVIEW PROTECTED HEALTH INFORMATION

Patient's name:_____Date of birth:_____

Address:_____Phone:_____

I hereby authorize **MY ENDOCRINOLOGIST** to use and disclose to____or obtain from____or allow for review ___

Name of facility or person: _____

Phone_____Fax_____

Address:_____

The following information contained in my medical record regarding hospitalization, care and treatment (please initial):

Complete records
Abstract of records
Therapy records
Progress notes_
All diagnostic test results
Consultations _
Radiology only _
Operative report_
Pathology reports
Lab results_

The purpose for the release of information at the request of the individual is:

Insurance_ Legal Action _ Continued treatment _ Personal use _

I understand that this authorization extends to all or any part of the records designated above, which may include psychiatric information, and/or genetic counseling/testing, and/or alcohol/drugs abuse, and/or AIDS (Acquired Immunodeficiency Syndrome), and/or may include the results of an HIV test or the fact that test was performed. I expressly consent to the release of information as designated above unless initiated below or otherwise required by law

May NOT include information related to (please initial)

HIV/AIDS _ Mental health _ Drug and/or alcohol abuse _

Genetic counseling/testing information _

If i fail to specify an expiration event or condition, the authorization will expire in one year. I understand that this authorization is revocable upon written notice to the office where the original authorization is retained, except to the extent that action has already been taken on this authorization. I understand that my protected health information that is used or disclosed unders this authorization may be subject to re-disclosure by the recipient and the privacy of my protected health information may no longer be protected by law. I further understand that My Endocrinologist may not condition the provision of treatment, payment, enrollment in the health plan, or eligibility for benefits on the provision of this authorization

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NO SHOW FEE

IMPORTANT NOTICE FOR ALL PATIENTS
AVISO IMPORTANTE PARA TODOS LOS PACIENTES

Effective Immediately...

Everyday there are on average 5 patients who do not show up for their appointments.
That creates a problem for other patients, who want to come in sooner and can't due to the lack of open slots on the schedule, and for the office.
This is why we will charge you a $ 50.00 dollar no show fee for follow up and $100.00 for new patients. If you don't call in advance to cancel or reschedule if you can't make it to your appointment.
Please be considerate with other patients and the office and call at least 24 hours in advance if you are not coming.
I understand that I will be charged for no show appointment in the amount of $50.00 dollar for follow up and $ 100.00 for new patient, this fee will be collected prior to being seen by the providers at your next scheduled appointment.

Thank you.

Todos los días hay por lo menos 5 pacientes que no vienen a su cita programada.
Esto continúa creando un problema para la oficina y para los pacientes, que quieren una cita pronto y no la obtienen por falta de espacio.
Por esta razón vamos a cobrarle $50 dólares para pacientes establecidos y $ 100.00 para pacientes nuevos por faltar a su cita y no dar aviso previo de queno podía asistir.
Por favor piense en otros pacientes que necesitan su ayuda y sino puede venir avise por lo menos con 24 horas de anticipación.
Entiendo que se me cobrará $50.00 dólares para pacientes establecidos 0 $100.00 para paciente nuevo sino cancelo la cita programada con la debida anterioridad. Este valor se cobrará en su próxima cita programada antes de ver a los proveedores.

Gracias.

Print Name (nombre del paciente) _____

Patient Signature (firma del paciente) _____

Date (fecha) _____

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Consent for Email and Text messages communication

Email and text messages allows My Endocrinologist, P.A. to exchange information efficiently for the benefit of our patients. At the same time we recognize that email and messaging is not a completely secure means of communication because the messages can be addressed to the wrong person or accessed improperly while in storage or during transmission.

If you would like us to send you emails that contains your health information, please complete and sign this consent below.

PLEASE PRINT CLEARLY. IF WE CAN NOT READ THIS WE CAN NOT EMAIL TO YOU

_____ _____ _____
NAME **DATE OF BIRTH** **LAST 4 OF YOUR SSN**

_____
EMAIL ADDRESS (PLEASE PRINT)

_____
PHONE NUMBER (TEXT MESSAGE)

_____ _____
SIGNATURE **DATE**