WILMINGTON ENDOCRINOLOGY PA

# Patient Registration Form

Name_____
Last First Middle

Address:_____
City State Zip

Home #:_____ Cell #:_____ Work #:_____

Primary Care Physician:_____ Referring Physician: _____

Date of Birth:_____

**Please Check:** Sex: ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Social Security #:_____ Employer/School: _____

Employer Address:_____ Employer #:_____

Emergency Contact:_____ Relation: _____ Phone #:_____

**Spouse Name or Parent/Guardian if Patient is under 18**:_____

Relationship to Patient:_____ DOB: _____ SSN: _____

Primary #:_____ Address:_____

**Insurance Information** (Please present Insurance Card at time of Check-In)

| Insurance Information | Primary | Secondary |
|---|---|---|
| Name of Insurance Company | | |
| Insurance ID # | | |
| Group ID # | | |
| Name of Policyholder/Subscriber | | |
| DOB of Policyholder/Subscriber | | |
| SSN of Policyholder/Subscriber | | |

Email:_____ Would you like Patient Portal? ☐Yes ☐No

Ok to Leave a Message at: Home and/or Cell

☐Brief ☐ Brief

☐Extended ☐Extended

Pharmacy:_____ Address:_____ Phone #:_____

**ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT. NECESSARY FORMS WILL BE COMPLETED TO HELP EXPEDITE INSURANCE CARRIER PAYMENTS. HOWEVER THE PATIENT IS RESPONSIBLE FOR ALL FEES, REGARDLESS OF INSURANCE COVERAGE.**

**INSURANCE AUTHORIZATION AND ASSIGNMENT**

I request the payment of authorized Medicare/other Insurance Company benefits be made to me or on my behalf to Wilmington Endocrinology, PA for any services furnished me by that party who accepts assignment/physician. Regulations pertaining to Medicare assignment of benefits apply.

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carries any information needed for this or related Medicare claim/other Insurance Company claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment. (Section 1128D of the Social Security Act & 31 USC 3801-3812 provides penalties for withholding this information.

**My signature below gives my acknowledgement and agreement to a $5.00 per month billing statement fee commencing after 60 days.**

Signature:_____ Date:_____

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## Consent for Purposes of Treatment, Payment, and Healthcare Operations

I consent to the use or disclosure of my protected health information by Wilmington Endocrinology for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Wilmington Endocrinology. I understand that diagnosis or treatment of me by Ghobad Azizi, MD may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Wilmington Endocrinology is not required to agree to the restrictions that I may request, the restriction is binding on Wilmington Endocrinology and Ghobad Azizi, MD.

I have the right to revoke this consent, in writing, at any time, except to the extent that Ghobad Azizi, MD or Wilmington Endocrinology has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information related to my past, present, or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review Wilmington Endocrinology's Notice of Privacy Practices prior to signing this document. Wilmington Endocrinology's Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Wilmington Endocrinology. The Notice of Privacy Practices for them is also provided in the waiting area. This Notice of Privacy Practices also describes my rights and Wilmington Endocrinology's duties with respect to my protected health information.

Wilmington Endocrinology reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____
Signature of Patient or Personal Representative

_____
Name of Patient or Personal Representative

_____
Date

_____
Description of Personal Representative's Authority

WILMINGTON ENDOCRINOLOGY PA

## Wilmington Endocrinology Insurance Policy

Welcome to our practice. We are committed to providing you with the best possible care and we are open to discussing our professional fees with you at any time.

Currently, we are participating with most major insurance companies. However, all deductibles, co-payments, and/or co-insurance payments are due at time of service. If your insurance has a percentage co-insurance, please be prepared to make this payment at the time of service.

Insurance is a contract between you and your insurance company. We cannot become involved in disagreements between you and the insurance company regarding deductibles, co-payments, covered charges, etc.

In order for insurance claims to be filed promptly it is your responsibility to inform our office of any changes to your insurance. If you do not provide correct insurance information to the office, this may result in claims being denied for timely filing. If a claim is denied for timely filing for this reason, you will be responsible for all charges.

## Wilmington Endocrinology Financial Policy

Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have any questions.

As per above payment is due at time of service. We accept cash, checks, Visa, MasterCard, and Discover.

Returned checks will be subject to additional collection fees. A $50 charge may also be assessed for no show appointments and same day cancellations.

Self Pay Patients must pay entire discounted amount on the date of service.
Patients with past due balances must pay entire balance plus today's charges.

We realize that temporary financial problems may affect timely payments of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account. Payment arrangements must be made prior to treatment.

Thank you for understanding our financial and insurance policies. If you have any questions about the above information, do not hesitate to ask us. We are here to assist you.

Signature:_____ Date:_____

Upon request a copy of this agreement will be given to the patient.

WILMINGTON ENDOCRINOLOGY PA

# Appointment Cancellation Policy

At Wilmington Endocrinology we strive to render excellent medical care to you and the rest of our patients. When an appointment is scheduled, that time has been set aside for you and when it is missed, that time cannot be used to treat another patient.

We request that you please give our office 24 hours notice in the event that you need to reschedule your appointment. This allows other patients to be scheduled into that appointment. It also makes it possible to reschedule your appointment more efficiently. If a patient misses an appointment without contacting our office, this is considered a missed appointment (NO SHOW). A $50 fee may be charged to you for the 2nd missed appointment. This fee must be paid before another appointment will be scheduled. If a patient accumulates a total of three (3) missed appointments, the patient may not be rescheduled for future appointments and will be asked to leave the practice.

Additionally, if a patient is more than 15 minutes late to his/her appointment, the appointment may be cancelled. New patient appointments cannot be rescheduled, as they often involve authorizations that are valid only for a specific amount of time.

I have read and understand the Appointment Cancellation Policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by the practice.

_____ _____

Patient Signature Date

_____

Printed Name of Patient

# History Questionnaire

Completed by: (Staff) (Patient) (Physician) on:_____

**Please Circle and Fill In Blanks**

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

**Occupation**: Retired Active:_____

**Do you: (Please Circle Yes or No and Explain if Yes)**

Live w/ Others: No Yes Who:_____
Have Children: No Yes # Living:_____ # Deceased:_____ Cause:_____
Get Exercise: No Yes Hours per Week:_____
Use Illegal Drugs: No Yes _____
Use Alcohol: No Yes Ounces per Day/Week:_____
Smoke: No Yes PPD:_____ Stopped:_____

**Have you ever had:**

Surgery: No Yes Date:_____ Hospital:_____
Reason:_____
Date:_____ Hospital:_____
Reason:_____
Date:_____ Hospital:_____
Reason:_____

Metal in Your Body: No Yes Location:_____
Heart Valves/Stents: No Yes Location:_____
Blood Transfusion: No Yes Date:_____ Hospital:_____
Reason:_____
An Illness: No Yes Date:_____ Hospital:_____
Reason:_____
Head & Neck Radiation: No Yes Date:_____ Hospital:_____
Reason:_____
Are you claustrophobic? No Yes

**Problems for which you have seen a physician or have been treated for:**

Diabetes: No Yes
Malignancy (Cancer): No Yes
Tumor/Lesion: No Yes
COPD: No Yes
Blood Pressure: No Yes
Heart Problem: No Yes
Infections: No Yes
Pain: No Yes
Nerves/Anxiety: No Yes
Thyroid: No Yes
Other:_____

**Autoimmune Diseases:**

Arthritis (Osteo): No Yes
Rheumatoid Arthritis: No Yes
Lupus or "SLE": No Yes
Gout: No Yes
Psoriasis: No Yes
Sjogren's Syndrome: No Yes
Other:_____

**Do any of your blood relatives have any of the following diseases? Do any other medical problems run in the family?**

| | | | |
|---|---|---|---|
| Diabetes: | No | Yes | Type:_____ |
| Cancer: | No | Yes | Location:_____ |
| Tumor/Lesion: | No | Yes | Location:_____ |
| Thyroid Disease: | No | Yes | Type:_____ |
| Stroke: | No | Yes | Date:_____ |
| Tuberculosis: | No | Yes | |
| High Blood Pressure: | No | Yes | |
| Heart Problem: | No | Yes | Type:_____ |
| Other Health Problems: | No | Yes | _____ |

**Please Circle and Fill in the Blank if Applicable:**

| | | | |
|---|---|---|---|
| Your Father: | Living | Deceased | ____/____/____ Cause:_____ |
| Your Mother: | Living | Deceased | ____/____/____ Cause:_____ |
| Your Brother(s): | Living | Deceased | ____/____/____ Cause:_____ |
| Your Sister(s): | Living | Deceased | ____/____/____ Cause:_____ |

**Please List all Medications and Supplements:**

| Name of Medication: | Strength: | Frequency: | Currently Taking: |
|---|---|---|---|
| _____ | _____ | _____ | No Yes |
| _____ | _____ | _____ | No Yes |
| _____ | _____ | _____ | No Yes |
| _____ | _____ | _____ | No Yes |
| _____ | _____ | _____ | No Yes |
| _____ | _____ | _____ | No Yes |
| _____ | _____ | _____ | No Yes |
| _____ | _____ | _____ | No Yes |
| _____ | _____ | _____ | No Yes |
| _____ | _____ | _____ | No Yes |
| _____ | _____ | _____ | No Yes |
| _____ | _____ | _____ | No Yes |

**Please Answer and Fill in the Blank if Applicable:**

Any Allergies: No Yes _____

_____

_____

_____

_____

_____

_____

_____

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

WILMINGTON ENDOCRINOLOGY PA

# Authorization for Release of Information

Name of Patient:_____ Date of Birth:_____

Wilmington Endocrinology, PA is authorized to release protected health information about the above named patient to entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions.

Please Check the Following:

| Entity to Receive Information: | Description of Information to be Released: |
|---|---|
| ☐ Voice Mail<br>☐ Home<br>☐ Cell | ☐ Financial:_____<br>☐ Medical as follows:_____<br>_____ |
| ☐ Spouse<br>Name: _____ | ☐ Financial:_____<br>☐ Medical as follows:_____<br>_____ |
| ☐ Parent/Guardian<br>Name: _____ | ☐ Financial:_____<br>☐ Medical as follows:_____<br>_____ |
| ☐ Other<br>Name:_____ | ☐ Financial:_____<br>☐ Medical as follows:_____<br>_____ |

**Patient Information**

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

*I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.* This authorization shall be in effect until revoked by the patient.

_____ _____

Signature of Patient or Personal Representative Date

_____

Description of Personal Representative's Authority
(attach necessary documentation)

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# Patient Extra Demographics

Patient Name:_____
Last First Middle

Date of Birth: _____

To comply with government standards relating to our electronic health record software we are required to capture certain demographic elements. Please help us so our records will be complete by answering the following questions. Thank you.

**Race?**

| | |
|---|---|
| | American Indian or Alaska Native |
| | Asian |
| | Native Hawaiian |
| | Black or African American |
| | White/Caucasian |
| | Hispanic or Latino |
| | Other Race |
| | Other Pacific Islander |
| | Prefer not to report |

**Ethnicity?**

| | |
|---|---|
| | Hispanic |
| | Non-Hispanic |
| | Prefer not to report |

**Preferred language?**

| | |
|---|---|
| | English |
| | Other |
| | Indian (includes Hindi & Tamil) |
| | Spanish |
| | Russian |

**Smoking Status**

**Are you a smoker?** ☐ **Yes** ☐ **No**

**Please check one**

| | |
|---|---|
| | Current Smoker |
| | Former Smoker |
| | Never Smoker |
| | Current Every Day Smoker |
| | Current Some Day Smoker |
| | Smoker, Current status |
| | Unknown if ever smoked |

Signature:_____ Date:_____

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**Bubble Sheet Instructions**

By filling out the following bubble sheets our clinical staff will be able to better assess your care. Please answer all questions, do not leave any blanks.

Please fill in each bubble completely using black ink or number 2 pencil. Do not mark outside of the bubble.

DO NOT WRITE ON FORM OR MARK OUTSIDE OF BUBBLE.

**Incomplete bubbles, x's or checks will NOT be recognized by the system.**

Correct marks: ●

Incorrect marks: ◙ ○ ☺ Ø X √


**General**

| | | | |
|---|---|---|---|
| Loss of appetite | O Yes | O No | O N/A |
| Weight loss | O Yes | O No | O N/A |
| Weight gain | O Yes | O No | O N/A |
| Fatigue | O Yes | O No | O N/A |
| Loss of height | O Yes | O No | O N/A |
| Insomnia | O Yes | O No | O N/A |
| Inability to lose weight | O Yes | O No | O N/A |

**Thyroid/Neck**

| | | | |
|---|---|---|---|
| Enlarged thyroid | O Yes | O No | O N/A |
| Palpable neck mass | O Yes | O No | O N/A |
| Choking Sensation | O Yes | O No | O N/A |
| Voice weakness | O Yes | O No | O N/A |
| Hoarseness | O Yes | O No | O N/A |
| Difficulty Swallowing | O Yes | O No | O N/A |
| Pressure in neck | O Yes | O No | O N/A |
| Neck Pain | O Yes | O No | O N/A |

**Eye**

| | | | |
|---|---|---|---|
| Loss of vision | O Yes | O No | O N/A |
| Decreased vision | O Yes | O No | O N/A |
| Double vision | O Yes | O No | O N/A |
| Bulging eyes | O Yes | O No | O N/A |
| Dry eyes | O Yes | O No | O N/A |

**Cardiac**

| | | | |
|---|---|---|---|
| Chest pain or pressure | O Yes | O No | O N/A |
| Palpitations | O Yes | O No | O N/A |
| Leg swelling | O Yes | O No | O N/A |

**Lungs**

| | | | |
|---|---|---|---|
| Shortness of breath | O Yes | O No | O N/A |
| Cough | O Yes | O No | O N/A |
| Wheezing | O Yes | O No | O N/A |

**Gastrointestinal**

| | | | |
|---|---|---|---|
| Diarrhea | O Yes | O No | O N/A |
| Vomiting | O Yes | O No | O N/A |
| Constipation | O Yes | O No | O N/A |
| Nausea | O Yes | O No | O N/A |
| Heartburn | O Yes | O No | O N/A |
| Abdominal pain | O Yes | O No | O N/A |

**Name:**_____ **DOB:**_____/_____/_____

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**Gynecological**

| | | | |
|---|---|---|---|
| Pregnant | O Yes | O No | O N/A |
| Hot flashes | O Yes | O No | O N/A |
| Amenorrhea | O Yes | O No | O N/A |
| Postmenopausal | O Yes | O No | O N/A |
| Breast tenderness | O Yes | O No | O N/A |
| Infertility | O Yes | O No | O N/A |
| Heavy menses | O Yes | O No | O N/A |
| Regular Menses | O Yes | O No | O N/A |

**Endocrinology**

| | | | |
|---|---|---|---|
| Excessive thirst | O Yes | O No | O N/A |
| Excessive urination | O Yes | O No | O N/A |
| Sensitive to hot temperature | O Yes | O No | O N/A |
| Sensitive to cold temperature | O Yes | O No | O N/A |
| Cold hands or feet | O Yes | O No | O N/A |
| Excessive sweating | O Yes | O No | O N/A |

**Musculoskeletal**

| | | | |
|---|---|---|---|
| Joint stiffness | O Yes | O No | O N/A |
| Joint pain | O Yes | O No | O N/A |
| Back pain | O Yes | O No | O N/A |
| Fracture | O Yes | O No | O N/A |
| Muscle cramping | O Yes | O No | O N/A |
| Muscle weakness | O Yes | O No | O N/A |
| Decrease in muscle mass | O Yes | O No | O N/A |
| Muscle Pain | O Yes | O No | O N/A |

**Neurologic**

| | | | |
|---|---|---|---|
| Frequent headache | O Yes | O No | O N/A |
| Tingling | O Yes | O No | O N/A |
| Tremor | O Yes | O No | O N/A |
| Numbness | O Yes | O No | O N/A |
| Migraines | O Yes | O No | O N/A |
| Burning pain in feet | O Yes | O No | O N/A |
| Burning pain in hands | O Yes | O No | O N/A |
| Lancinating pains in feet | O Yes | O No | O N/A |
| Vertigo | O Yes | O No | O N/A |
| Sciatica | O Yes | O No | O N/A |
| Weakness | O Yes | O No | O N/A |
| Dizziness | O Yes | O No | O N/A |


**Dermatology**

| | | | |
|---|---|---|---|
| Excessive hair growth | O Yes | O No | O N/A |
| Excessive dry skin | O Yes | O No | O N/A |
| Hair loss | O Yes | O No | O N/A |
| Acne | O Yes | O No | O N/A |
| Itching | O Yes | O No | O N/A |
| Loss of pigmentation | O Yes | O No | O N/A |
| Rash | O Yes | O No | O N/A |

**Psychiatric**

| | | | |
|---|---|---|---|
| Depression | O Yes | O No | O N/A |
| High stress level | O Yes | O No | O N/A |
| Sleep disturbances | O Yes | O No | O N/A |
| Eating disorder | O Yes | O No | O N/A |
| Mood swings | O Yes | O No | O N/A |
| Anxiety | O Yes | O No | O N/A |

**Name:**_____ **DOB:**_____/_____/_____