



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: _____

History Questionnaire

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

Please Circle and Fill in the Blanks

SOCIAL HISTORY:

Occupation: Retired Active: _____

Live With others: No Yes Who: _____

Children: No Yes # Sons: _____ # Daughters: _____

Exercise: No Yes Hours Per Week: _____

Illegal Drug Use: No Yes Type: _____

Alcohol Use: No Yes *If yes, please answer these additional questions (Circle One for Each):*

How often did you have a drink containing alcohol in the past year?

Never Monthly or Less 2-4x/Month 2-3x/Week $\geq 4x/Week$

How many drinks did you have on a typical day when you were drinking in the past year?

1-2 3-4 5-6 7-9 ≥ 10

How often did you have ≥ 6 drinks on one occasion in the past year?

Never Less than Monthly Monthly Weekly Daily/
Almost Daily

Smoke Tobacco: Never Smoker Current Smoker Former Smoker
Start: _____ Start: _____ PPD: _____
PPD: _____ Quit: _____

Claustrophobic: No Yes

If 65 Years or Older: Have you had a pneumonia vaccination in the past?

No Yes Approximate Date: _____

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

Please Answer and Fill in the Blank:

Any Allergies? No Yes _____

PERSONAL MEDICAL HISTORY

Do you currently have or have you ever been diagnosed with the following problems?

Diabetes: No Yes
COPD: No Yes
High Blood Pressure: No Yes
Heart Problem: No Yes
Frequent Infections: No Yes
Anxiety: No Yes
Depression: No Yes
Kidney Stones: No Yes
Cancer: No Yes
Thyroid Disorder: No Yes
Other: _____

Autoimmune Disease:

Osteoarthritis: No Yes
Rheumatoid Arthritis: No Yes
Lupus or SLE: No Yes
Psoriasis: No Yes
Sjogren's: No Yes
Other: _____

If yes, specify: _____
If yes, specify: _____

Metal in Your body: No Yes Location: _____
Head/Neck Radiation: No Yes Date: _____ Hospital: _____
Reason: _____
Heart Valves/Stents: No Yes

Surgeries: Date: _____ Type of Surgery: _____
Surgeon/Hospital: _____
Date: _____ Type of Surgery: _____
Surgeon/Hospital: _____
Date: _____ Type of Surgery: _____
Surgeon/Hospital: _____
Date: _____ Type of Surgery: _____
Surgeon/Hospital: _____

Please Circle and Fill in the Blank for Blood Relatives:

Father: Living / Deceased Cause of Death: _____
Mother: Living / Deceased Cause of Death: _____
Brother(s): #__ Living #__ Deceased Cause of Death: _____
Sister(s): #__ Living #__ Deceased Cause of Death: _____

FAMILY MEDICAL HISTORY:

If any of your blood relatives have ever been diagnosed with the following, please circle Yes and specify who and what type. (Please specify maternal/paternal)

Diabetes: No Yes Who: _____
Cancer: No Yes Type: _____
Tumor/Lesion: No Yes Type: _____
Stroke: No Yes Who: _____
Heart Problem: No Yes Who: _____
High Blood Pressure: No Yes Who: _____
Autoimmune Disease: No Yes Who/Type: _____
Thyroid Disease: No Yes Who/Type: _____
Thyroid Cancer: No Yes Who/Type: _____
Other Problems: No Yes Specify: _____

Patient Name: _____

Date of Birth: _____



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?

<input type="checkbox"/>	American Indian or Alaska
<input type="checkbox"/>	Asian
<input type="checkbox"/>	Native Hawaiian
<input type="checkbox"/>	Black or African American
<input type="checkbox"/>	White/Caucasian
<input type="checkbox"/>	Hispanic or Latino
<input type="checkbox"/>	Other Pacific Islander
<input type="checkbox"/>	Other Race
<input type="checkbox"/>	Prefer not to report

Ethnicity?

<input type="checkbox"/>	Hispanic
<input type="checkbox"/>	Non-Hispanic
<input type="checkbox"/>	Prefer not to report

Preferred language?

<input type="checkbox"/>	English
<input type="checkbox"/>	Spanish
<input type="checkbox"/>	Indian (includes Hindi & Tamil)
<input type="checkbox"/>	Russian
<input type="checkbox"/>	Other:

Signature: _____ Date: _____



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 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.



E-PRESCRIBING CONSENT FORM

ePrescribing is defined by a physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care.

ePrescribing greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act (MMA) 2003 listed standards that have to be included in an ePrescribe program.

These include:

- **Formulary and benefit transactions**
Gives the prescriber information about which drugs are covered by the drug benefit plan.
- **Medication history transactions**
Provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events.
- **Fill status notification**
Allows the prescriber to receive an electronic notice from the pharmacy telling them if the patient's prescription has been picked up, not picked up, or partially filled.

By signing this consent form you are agreeing that Wilmington Endocrinology, PA can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

Understanding all of the above, I hereby provide informed consent to Wilmington Endocrinology, PA to enroll me in the ePrescribe program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

Patient Name

Date of Birth

Signature of Patient or Representative

Date



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



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 in the following manner and to identified persons.

Please Check the Following:

Entity to Receive Information: Check each person/entity that you approve to receive information	Description of Information to be Released: Check each that can be given to person/entity on the left in the same section.
<input type="checkbox"/> Voice Mail <input type="checkbox"/> Home <input type="checkbox"/> Cell	<input type="checkbox"/> Results of lab tests/x-rays <input type="checkbox"/> Other: _____
<input type="checkbox"/> Spouse Name: _____ Phone Number: _____	<input type="checkbox"/> Financial <input type="checkbox"/> Medical
<input type="checkbox"/> Other person(s) Name: _____ Phone Number: _____	<input type="checkbox"/> Financial <input type="checkbox"/> Medical
<input type="checkbox"/> Email communication-Provide email address* _____ *For email communication to occur, please accept the disclosure below:	<input type="checkbox"/> Medical Communication such as: Thyroid Research Medical Articles, Publication Notifications, Holiday Greetings, Newsletters <input type="checkbox"/> Results of lab tests/x-rays, upon request
For email and/or text communication I understand that if information is NOT sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to receive email and/or text communication as selected.	
X _____ Signature Authorizing Email Communication	

Patient Rights:

- I have the right to revoke this authorization at any time.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

This authorization will remain in effect until revoked by the patient.

X _____
 Signature of Patient or Personal Representative

 Date

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



General

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

Thyroid/Neck

- Palpable neck mass Yes No N/A
- Choking sensation Yes No N/A
- Enlarged thyroid Yes No N/A
- Voice weakness Yes No N/A
- Hoarseness Yes No N/A
- Difficulty swallowing Yes No N/A
- Pressure in neck Yes No N/A
- Neck pain Yes No N/A

Eyes

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

Cardiac

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

Lungs

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

NP Malep1 DPI200*center **Name:** _____ **DOB:** ____/____/____



Gastrointestinal

- | | | | |
|----------------------|---------------------------|--------------------------|---------------------------|
| | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> N/A |
| Vomiting | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> N/A |
| Constipation | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> N/A |
| Nausea | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> N/A |
| Heartburn | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> N/A |
| Abdominal pain | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> N/A |
| Erectile dysfunction | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> N/A |
| Difficulty urinating | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> N/A |

Endocrinology

- | | | | |
|-------------------------------|---------------------------|--------------------------|---------------------------|
| Decreased libido | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> N/A |
| Excessive thirst | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> N/A |
| Excessive urination | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> N/A |
| Sensitive to hot temperature | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> N/A |
| Sensitive to cold temperature | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> N/A |
| Cold hands or feet | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> N/A |
| Urination at night | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> N/A |
| Breast growth (men) | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> N/A |
| Breast tenderness | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> N/A |
| Excessive hunger | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> N/A |
| Brittle nails | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> N/A |
| Breast discharge | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> N/A |
| Excessive sweating | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> N/A |

Musculoskeletal

- | | | | |
|-------------------------|---------------------------|--------------------------|---------------------------|
| Joint stiffness | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> N/A |
| Joint pain | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> N/A |
| Back pain | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> N/A |
| Fracture | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> N/A |
| Muscle cramping | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> N/A |
| Muscle weakness | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> N/A |
| Decrease in muscle mass | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> N/A |
| Muscle pain | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> N/A |

NP Malep2DPI200* center **Name:** _____ **DOB:** ____/____/____



Neurologic

- | | | | |
|-----------------------|---------------------------|--------------------------|---------------------------|
| Frequent headache | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> N/A |
| Tingling | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> N/A |
| Tremor | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> N/A |
| Numbness | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> N/A |
| Migraines | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> N/A |
| Burning pain in feet | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> N/A |
| Burning pain in hands | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> N/A |
| Vertigo | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> N/A |
| Dizziness | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> N/A |

Dermatology

- | | | | |
|-----------------------|---------------------------|--------------------------|---------------------------|
| Excessive hair growth | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> N/A |
| Excessive dry skin | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> N/A |
| Hair loss | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> N/A |
| Acne | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> N/A |
| Itching | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> N/A |
| Loss of pigmentation | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> N/A |
| Rash | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> N/A |

Psychiatric

- | | | | |
|---|---------------------------|--------------------------|---------------------------|
| Depression | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> N/A |
| Little interest or pleasure in doing things | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> N/A |
| Feeling down, depressed, or hopeless | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> N/A |
| High stress level | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> N/A |
| Eating disorder | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> N/A |
| Mood swings | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> N/A |
| Anxiety | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> N/A |