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:_____

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 ≥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 Start: _____ PPD: _____ Former Smoker Start: _____ Quit: _____ PPD:_____

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
_____	_____	_____	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: _____

Metal in Your body:	No	Yes
Head/Neck Radiation:	No	Yes
Heart Valves/Stents:	No	Yes

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: _____

Location: _____

Date: _____ Hospital: _____

Reason: _____

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**:_____

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 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.
☐ **Voice Mail** ☐ Home ☐ Cell	☐ Results of lab tests/x-rays ☐ Other: _____
☐ **Spouse** Name: _____ Phone Number:_____	☐ Financial ☐ Medical
☐ **Other person(s)** Name: _____ Phone Number:_____	☐ Financial ☐ Medical
☐ **Email communication-Provide email address*** _____ *For email communication to occur, please accept the disclosure below:	☐ Medical Communication such as: Thyroid Research Medical Articles, Publication Notifications, Holiday Greetings, Newsletters ☐ 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)

Revised August 2017