

PATIENT INFORMATION

Thank you for choosing our office! To properly serve you, we need the following information. (Please Print) All information is confidential.										
Today's date:					Registration #:					
Patient's last name:			First:		Middle:		<input type="checkbox"/> Mr.	<input type="checkbox"/> Miss	Marital status (circle one)	
							<input type="checkbox"/> Mrs.	<input type="checkbox"/> Ms.	Single / Mar / Div / Sep / Wid	
Is patient a minor?		If yes, parent name?			Birth date:			Age:	Sex:	
<input type="checkbox"/> Yes	<input type="checkbox"/> No				/ /				<input type="checkbox"/> M	<input type="checkbox"/> F
Street address:				Social Security no.:			Home phone no.:			
							()			
Student: <input type="checkbox"/> Yes <input type="checkbox"/> No		City:		State:		Zip Code:		Cell phone no:		
								()		
College/School:		Employer:			Employer phone no.:					
					()					
Referring Doctor										
Family Doctor										
Other family members seen here:										
Where do you prefer to receive calls? <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell _____ Best time to reach you _____										
INSURANCE INFORMATION										
(Please give your insurance card to the receptionist.)										
Person responsible for bill:		Birth date:		Address (if different):				Home phone no.:		
		/ /						()		
Is this person a patient here?		<input type="checkbox"/> Yes	<input type="checkbox"/> No							
Occupation:	Employer:		Employer address:				Employer phone no.:			
							()			
Is this patient covered by insurance?		<input type="checkbox"/> Yes	<input type="checkbox"/> No							
Please indicate primary insurance		<input type="checkbox"/> Priority Health		<input type="checkbox"/> BC/BS		<input type="checkbox"/> HAP		<input type="checkbox"/> Medicare		<input type="checkbox"/> Other:
Subscriber's name:		Subscriber's S.S. no.:		Birth date:		Group no.:		Policy no.:		Co-payment:
				/ /						\$
Patient's relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other					
Name of secondary insurance (if applicable):		Subscriber's name:				Group no.:		Policy no.:		
Patient's relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other					
IN CASE OF EMERGENCY										
Name of local friend or relative (not living at same address):				Relationship to patient:		Home phone no.:		Work phone no.:		
						()		()		
The above information is true to the best of my knowledge. I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the doctor.										
Patient/Guardian signature								Date		

ADDITIONAL INFORMATION

(Please Print) All information is confidential.

Today's date:		Registration #:			
Patient's last name:	First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	
Is patient a minor?	If yes, parent name?		Birth date:		Age: Sex:
<input type="checkbox"/> Yes <input type="checkbox"/> No			/ /		<input type="checkbox"/> M <input type="checkbox"/> F

Name of Referring Physician _____

Name of Primary Care Physician _____

Why are you seeing the doctor today? _____

Please list all medications you take:

Name of Medication	Dosage	# Times Per Day

List any other medications you have taken during the past 6 months but are no longer taking:

Name of Medication	Dosage	Date Stopped	Why Stopped

Past Medical History:

Do you have a personal history of:

- | | | | |
|---|---|---|---------------------------------------|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Hypertension |
| <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Hormone or gland condition | <input type="checkbox"/> Asthma | <input type="checkbox"/> Kidney Failure | |
| <input type="checkbox"/> Other _____ | | | |

Please list any surgeries or operations that you have had and approximate dates:

Family History:

Do any close relatives have a history of (and who _____):

- | | | |
|---|--|--|
| <input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> High Cholesterol _____ | <input type="checkbox"/> Osteoporosis _____ |
| <input type="checkbox"/> Hypertension _____ | <input type="checkbox"/> Thyroid Disease _____ | <input type="checkbox"/> Heart Disease _____ |
| <input type="checkbox"/> Stroke _____ | <input type="checkbox"/> High calcium or parathyroid _____ | |

Do you smoke? Yes No. If yes, how many packs/day? _____ For how long? _____If you do not smoke, did you smoke in the past? Yes No. For how long? _____ When did you quit? _____

Number of alcoholic beverages consumed in a typical week (includes beer, wine, liquor)? _____

What is your occupation? _____ Marital Status _____

Weight _____ Menstrual Cycle: Regular Irregular. Pregnant: Yes No.

ADDITIONAL INFORMATION – REVIEW OF SYSTEMS

(Please Print) All information is confidential.

Today's date:		Registration #:	
Patient's last name:	First:	Middle:	

Do you now, or have you recently had, any problems related to the following systems? Circle Yes or No please.

Constitutional Symptoms

Fever	Yes	No
Chills	Yes	No
Night Sweats	Yes	No
Change in appetite, weight, energy	Yes	No

Explain _____

Eyes

Blurred Vision	Yes	No
Double Vision	Yes	No
Pain	Yes	No

Explain _____

Allergic / Immunologic

Hay Fever	Yes	No
Drug Allergies	Yes	No

Explain _____

Neurological

Tremors	Yes	No
Dizzy Spells	Yes	No
Numbness / tingling	Yes	No
Seizures	Yes	No

Explain _____

Endocrine

Excessive thirst	Yes	No
Too hot / cold	Yes	No
Tired / sluggish	Yes	No

Explain _____

Gastrointestinal

Abdominal Pain	Yes	No
Nausea / vomiting	Yes	No
Indigestion / heartburn	Yes	No
Change stool size/shape/color	Yes	No
Pain with swallowing	Yes	No

Explain _____

Cardiovascular

Chest Pain	Yes	No
Rapid Heart Rate	Yes	No
High Blood Pressure	Yes	No

Explain _____

Integumentary

Skin Rash	Yes	No
Boils	Yes	No
Persistent Itch	Yes	No

Explain _____

Musculoskeletal

Neck Pain	Yes	No
Joint Swelling/pain	Yes	No
Back Pain	Yes	No
Bone Pain	Yes	No

Explain _____

Ear/Nose/Throat/Mouth

Ear Infection	Yes	No
Sore Throat	Yes	No
Sinus Problem	Yes	No
Bleeding from ears, nose, gums	Yes	No

Explain _____

Genitourinary

Urine retention	Yes	No
Painful urination	Yes	No
Urinary frequency	Yes	No
Change in urine stream	Yes	No

Explain _____

Respiratory

Wheezing	Yes	No
Frequent Cough	Yes	No
Shortness of Breath	Yes	No

Explain _____

Hematologic / Lymphatic

Swollen glands	Yes	No
Blood clotting problem	Yes	No
Prior blood transfusions	Yes	No

Explain _____

Psychological

Are you generally satisfied with your life?	Yes	No
Do you feel severely depressed	Yes	No
Have you considered suicide	Yes	No

Explain _____

Signature of Physician: _____ Date: _____

**INSURANCE/REFERRAL AND “NO SHOW” POLICY
(OUR FINANCIAL POLICY)**

We are dedicated to providing the best possible care for you, and we want you to completely understand our financial policies.

1. Payment is due at the time of service unless arrangements have been made in advance by your carrier.
2. Health plans or insurance companies may require a referral to be seen by our doctors. You must have a current referral to be seen in the practice or you may not be seen. You and your physician, not our office, is responsible for obtaining the referral prior to your visit. If you do not have a referral and circumstances involving your care require immediate attention, then you will be asked to sign a form that obligates you for payment until such referral is obtained. If you cannot obtain that referral then you will be responsible for full payment.
3. Keep in mind that your insurance policy is basically a contract between you and your insurance company. As a service to you, we will file your insurance claim if you assign the benefits to the doctor – in other words, if you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment. If we later receive a check from your insurer, we will refund any overpayment to you.
4. We have made prior arrangements with many insurance companies and other health plans to accept an assignment of benefits. We will bill them, and you are required to pay a co-payment at the time of your visit.
5. Not all insurance plans cover all services. In the event your insurance plan determines a service to be “not covered”, you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.
6. We will bill your insurance company for all services provided in the hospital. You are responsible for any balance due.

**INSURANCE/REFERRAL
OUR FINANCIAL POLICY**

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7. Failure to honor financial obligations or “no shows” for visits may lead to termination from the practice/physician’s office. You will be notified in writing of such termination. Our physicians will continue to serve you for 30 days (unless otherwise specified) allowing you and your referring physician to make alternative arrangements for your care.

8. Our office manager(s) is available to answer any specific insurance or financial questions.

Signature of patient (or responsible party, if minor)

Date

Please print the name of the patient

Jas/kr
11/05

ANN ARBOR

Endocrinology
& Diabetes
ASSOCIATES, PC

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Reichert Health Building
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www.annarborendo.com

**ACKNOWLEDGEMENT
RECEIPT OF NOTICE OF PRIVACY PRACTICES**

By signing below, I acknowledge that I have received the Notice of Privacy Practices from Ann Arbor Endocrinology and Diabetes Associates, P.C.

WITNESSES:

Patient Signature

Date

Witness Signature

Date

Any specific requests/requirements: _____

Documentation of Failure to Obtain Signed Acknowledgement

On _____, _____ presented this Acknowledgment of
(day/mo/yr) (name of employee)

Receipt of Notice of Privacy Form to _____. The patient refused to provide a signature when requested.