Patient Registration Form

(ALL INFORMATION NEED TO BE COMPLETED!!!!!!) Please Print

Patient's Name (Last) _____ (First) _____Middle____

Marital Status □Married □Single □Divorced □Widowed □Legally separated □Other

Social Security Number____-__-____ □Female □Male Date of Birth / /

E-Mail Address _____

Phone Numbers: Cellular_____ Home_____

Address:_____ City, St, Zip_____

Emergency Contact_____ Phone Number_____

Relationship to Patient_____

Referring Provider Name_____ Phone Number_____

Primary Care Provider_____ Phone Number: _____

Pharmacy Name_____ Address_____

PRIMARY INSURANCE INFORMATION (provide your insurance card and license to the front desk at checkin)

Primary Insurance Holder Name_____ Date of Birth_____

Relationship to Insured_____ Insurance Phone Number_____

Name of Insurance_____ Phone_____

Subscriber ID (Policy Number)_____ Group ID_____

Insured's Social Security Number___-___-____

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.
Patient (or Responsible Party)
Signature _____Date_____

North Dallas Endocrinology

Endocrinology History Form

Name: _____DOB: _____Date: _____
How did you hear about our practice? Please state health care provider's name if you were referred:_____Age:_____
PCP:
Please list which health care provider you want notes sent to on a REGULAR basis (choose one):
What brings you in to see us today? (For example "diabetes"):

Symptoms: Do you have any of the following? (Please check box if yes, unchecked boxes mean no)

General	YES	Cardiovascular	YES	Reproductive/ Sexual	YES
Fever or chills		Chest pain		Irregular menses (female only)	
Recent weight change		Heart skips beats			
Heat or cold intolerance		Heart beats too fast		Change in sex drive	
Tired		Leg swelling		Difficulty with erections (male only)	
Head and Neck	**YES**	**Respiratory**	**YES**	**Gastrointestinal**	**YES**
Blurry vision		Cough		Constipation	
Decreased vision		Wheezing		Frequent diarrhea	
Change in hearing or ear pain		Shortness of breath		Nausea or vomiting	
Sore Throat				Black or bloody stools	
				Difficulty swallowing	
Skin	**YES**	**Musculoskeletal**	**YES**	**Neurological**	**YES**
Easy bruising		Fractures		Depression/ Anxiety	
Rash		Joint Swelling/ Pain		Fainting or blacking out	
		Muscle pain		Headaches	

PRESCRIPTION MEDICATIONS:
Please list all of your prescription medications. (If you need additional space please bring a list, including dosages, to your appointment or all your medications) Include **Medication Name, Dosage and Number of Times per Day:**

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Vitamins/
Supplements:

Please list allergies

Medication	Reaction

Vitals: (Office use only)Height_____ Weight_____ B/P_____ Pulse_____ Respirations_____

North Dallas Endocrinology

Past Medical History: Please check if you have or had any of the following and list any other conditions you may have:

Medical Condition:	YEAR DIAGNOSED	OTHER MEDICAL CONDITIONS:	YEAR DIAGNOSED
Diabetes		Thyroid Cancer	
Hypothyroidism		Addison's Disease	
Hyperthyroidism		Pituitary Tumor	
Thyroid Nodule		Other:	
Osteoporosis			
High Blood Pressure			
High Cholesterol			

Other Medical Conditions not listed above:

Please list surgeries and an approximate date:

Date	Reason for surgery

Family History: List your immediate family members including brothers, sisters and children and their health problems:

Relative	X if Deceased	Age	Health Problems
Father			
Mother			
Brother/Sister			
Brother/Sister			
Son/ Daughter:			
Grandparents:			

Social History:

Marital Status: Single _____ Divorced _____ Married _____ Widow/Widower _____ Other _____
Do you smoke? Yes _____ No _____ If yes, how many packs per day?_____ Number of Years: _____
Did you smoke? Yes _____ No _____ If yes, when did you quit? _____ Number of Years Smoked: _____
Do you drink alcohol? Yes _____ No _____ If yes, How often, what type and how much?

_____

Did you or do you use recreational or IV drugs?

_____

Number of children: _____ Occupation: _____
Hobbies/ Past Times:

Patient Signature: _____ Date:_____
Physician Signature: _____ Date:_____

N O R T H D A L L A S E N D O C R I N O L O G Y , P . A .

P A T I E N T A U T H O R I Z A T I O N T O D I S C L O S E P E R S O N A L H E A L T H I N F O R M A T I O N

Patient: _____
(First Name) (Middle Initial) (Last Name)

Address: _____

Date of Birth: _____

North Dallas Endocrinology, P.A. is authorized to **furnish to / receive from** (circle desired choice):

Recipient/Discloser: _____

For the Purpose of : _____
(optional)
_____

I AUTHORIZE RELEASE OF THE FOLLOWING MEDICAL RECORDS:

- ❑ I GIVE PERMISSION TO RELEASE ALL MY MEDICAL RECORDS including information and records or copies of records relating to the history, diagnosis, treatment or services rendered to me in connection with any condition or disease. This includes permission to release POTENTIALLY SENSITIVE INFORMATION which may include information concerning my treatment of mental illness, Human Immunodeficiency Virus (HIV), alcoholism, drug use/dependency, venereal disease, sexual assaults, abortion, illegitimacy of birth, communications to social workers and/or psychotherapies, psychologists, if any.

- ❑ I GIVE PERMISSION TO RELEASE ONLY RECORDS specifically described below:
  _____
  _____

I release North Dallas Endocrinology, P.A., and the Recipient/Discloser listed above, and any of their providers and staff from all responsibility or liability that may arise from this authorization. I may withdraw this authorization at any time by giving written notification to North Dallas Endocrinology, P.A., provided that I do so in writing and to the extent that you have already disclosed the information in reliance on this authorization.

This Authorization expires on ____/____/____ *(Optional) If no expiration date is given, then this authorization shall remain in effect for a period reasonably needed to complete the request.*

_____ _____
Patient Signature (Parent's Representative if minor) Date

_____ _____
Witness Signature Date

So that we may improve our patient care, please let us know the reason you are requesting this record release (check all that apply):

- ❑ Not satisfied with Provider (which provider? _____)
- ❑ Not satisfied with Staff (which staff member? _____)
- ❑ Moving out of the area?
- ❑ Other (Please describe :_____)

4325 NORTH JOSEY LANE, PLZ THREE, STE 203
CARROLLTON, TX 75010
PHONE (972)899-2271 FAX (972)492-5386

North Dallas Endocrinology Payment Policy

Thank you for choosing us as your medical provider. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. Insurance. We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. Co-payments and deductibles. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

3. Non-covered services. Please be aware that some – and perhaps all – of the services you receive may not be covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.

4. Proof of insurance. All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

5. Claims submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

6. Coverage changes. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

7. Nonpayment. If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted

unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

8. Missed appointments. Our policy is to charge for missed appointments not canceled within a reasonable amount of time. These charges will be your responsibility and billed directly to you. There is a $20 charge for an appointment that is cancelled without 24 hour notice. Please bear in mind that this is an inconvenience for the practice as well as other patients who are waiting to be seen sooner. Please help us to serve you better by keeping your regularly scheduled appointment.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.

Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

_____ _____

Signature of patient or responsible party **Date**

N O R T H D A L L A S E N D O C R I N O L O G Y

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for NORTH DALLAS ENDOCRINOLOGY to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations. (The Notice of Privacy provided by NORTH DALLAS ENDOCRINOLOGY describes such uses and disclosures more completely and is available for review on request).

I have the right to review the Notice of Privacy NORTH DALLAS ENDOCRINOLOGYs prior to signing this consent. NORTH DALLAS ENDOCRINOLOGY reserves the right to revise its Notice of Privacy NORTH DALLAS ENDOCRINOLOGYs at any time. A revised Notice of Privacy NORTH DALLAS ENDOCRINOLOGYs may be obtained by forwarding a written request to NORTH DALLAS ENDOCRINOLOGY

With this consent, NORTH DALLAS ENDOCRINOLOGY may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the NORTH DALLAS ENDOCRINOLOGY in carrying out TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, NORTH DALLAS ENDOCRINOLOGY may mail to my home or other alternative location any items that assist the NORTH DALLAS ENDOCRINOLOGY in carrying out TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS, such as appointment reminder cards and patient statements."

With this consent, NORTH DALLAS ENDOCRINOLOGY may e-mail to my home or other alternative location any items that assist the NORTH DALLAS ENDOCRINOLOGY in carrying out TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS, such as appointment reminder cards and patient statements. I have the right to request that NORTH DALLAS ENDOCRINOLOGY restrict how it uses or discloses my PHI to carry out TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS. The NORTH DALLAS ENDOCRINOLOGY is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow NORTH DALLAS ENDOCRINOLOGY to use and disclose my PHI to carry out treatment, payment, and health care operations.

I may revoke my consent in writing except to the extent that the NORTH DALLAS ENDOCRINOLOGY has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, NORTH DALLAS ENDOCRINOLOGY may decline to provide treatment to me.

Restrictions as per patient request (for example “please do not email”):

Signed by: _____ _____ _____

Signature of Patient or Legal Guardian | Date | Relationship to Patient

_____ _____

Print Patient’s Name | Print Name of Legal Guardian, if applicable

Patient/guardian must be provided with a signed copy of this authorization form.