M. Moosa, MD
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Endocrine Specialists, PC

Alison Fleig, PA-C
Rachel Kindred, PA-C

Email: *Call@EndoMDs.com*
Phone: *734-682-5243* ■ *419-724-0004*
Fax: *888-677-1987* ***Web:*** *www.EndoMDs.com*

15506 S. Telegraph Rd, ***Monroe****, MI 48161*
2702 Navarre Ave. Suite 106, ***Oregon****, OH 43616*
6855 Spring Valley Drive #150, ***Holland****, OH 43528*

WELCOME TO OUR OFFICE

Your appointment is on_____ at _____AM / PM

Location:

15506 S. Telegraph Rd., Monroe MI 48161

6855 Spring Valley Dr. #150, Holland OH 43528

2702 Navarre Ave. #106, Oregon OH 43616

Patient instructions:

1. Bring ***PHOTO ID*** and ***INSURANCE CARD***(s) to your appointment
2. Be prepared to pay ***COPAY*** amount if applicable
3. Bring or have sent to us ***RECENT TEST RESULTS*** – our fax # is 888-677-1987
4. Bring fully completed attached paperwork
5. If ***Diabetic*** – bring ***SUGAR NUMBERS***

IF ANY OF THE ABOVE IS NOT AVAILABLE YOUR APPOINTMENT MAY BE CANCELLED OR DELAYED

ENDOCRINE SPECIALISTS, PC

PATIENT REGISTRATION

PATIENT LAST NAME:	**Preferred Appointment Confirmation** – ❑Phone ❑Text
FIRST NAME:	Assigned Physician you want to see in our clinic: ❑Dr. Moosa ❑ _____
Middle Initial:	Referring Physician:
Date Of Birth:	Referring Physician Phone:
Sex/Gender: ❑Male ❑ Female ❑ _____	Primary Care Physician:
Marital Status: ❑Single ❑Married ❑ _____	Primary Care Physician Phone:
SOCIAL SECURITY NO.:	Whom may we thank for referring you?
FULL MAILING ADDRESS :	**FACILITY** you want to be seen: ❑Monroe ❑Holland ❑Oregon
Address	Employer's Name:
Zip	Employer's Phone:
City	Pharmacy Name/Location:
State	Pharmacy Phone:
HOME PHONE:	Nickname:
MOBILE PHONE:	Language: ❑English ❑Spanish ❑French ❑ _____
WORK PHONE:	Race:
EMAIL:	Ethnicity: ❑Hispanic ❑Non-Hispanic
Communication - Best Way to contact you: ❑Home Ph ❑Mobile Ph ❑Work Ph ❑Email	Smoking: ❑Currently Daily ❑Currently Some Days ❑Former ❑Never
EMERGENCY CONTACT NAME:	
Emergency Contact Phone:	

GUARANTOR'S INFORMATION (Financially Responsible Party **if different from Patient**)	**GUARANTOR'S ADDRESS (if different from Patient)**
Is Guarantor an **Existing Patient** in our clinic?	Address
Relationship to Patient:	City
GUARANTOR'S LAST NAME:	State
FIRST NAME:	Zip
Middle Initial:	**GUARANTOR'S HOME PHONE (if different from Patient)**
Date Of Birth:	Mobile Phone
Sex :	Work Phone
Social Security No.:	Email

ENDOCRINE SPECIALISTS, PC

PATIENT REGISTRATION

PRIMARY INSURANCE NAME:	**SECONDARY INSURANCE NAME:**
Member ID:	Member ID:
Insured Last Name:	**Insured Last Name:**
Insured First Name:	Insured First Name:
Insured Date of Birth:	Insured Date of Birth:
Relationship to Insured:	Relationship to Insured:

CONSENTS

I permit Endocrine Specialists PA team to discuss the patient's protected health information with:

_____ Relationship to Patient _____

_____ Relationship to Patient _____

I, the undersigned responsible party, hereby authorize the physicians and staff of Endocrine Specialists, PC to provide medical evaluation and treatment to the patient named below. I am responsible for any charges incurred during the course of my treatment, including any applicable copays, deductibles or other services not covered by any insurance plan I am covered by.

I, the undersigned responsible party, hereby authorize Endocrine Specialists, PC to release and disclose all or any part of the patient's medical record to any entity which is, or may be liable for all or part of the provider charges.

I authorize the release and disclosure of any and all of the patient's medical record to any other entity, including but not limited to, specialty physicians, hospitals, or other healthcare providers which may be of assistance in the opinion of this office, in providing for the treatment of the patient.

I authorize release of records to assist in the reimbursement of benefits to which I may be entitled. I authorize and request that payment of any third party or insurance company benefits be made to this office for any services furnished to the patient. The signature furnished below shall suffice for all insurance forms on a continuing basis.

I have been given or have access to the Notice of Privacy Practices. I have the right to request that Endocrine Specialists, PC restrict how it uses or discloses my PHI to carry out treatment, payment, and healthcare operations. I may revoke in writing except to the extent that the practice has already made disclosure in reliance upon prior consent. If I do not sign this consent, Endocrine Specialists, PC may decline to provide treatment to me.

I understand and agree to being charged for missing, rescheduling or canceling my appointment in less than twenty four (24) hours before its time.

Signature of: ❑ Patient ❑ Parent ❑ Legal Guardian

❑ Authorized Representative ❑ Designated Power of Attorney (DPOA) for Health Care

_____ _____ _____

Printed Name Signature Date

Endocrine Specialists, PC

Name: _____ DOB: _____ Date: _____

I am MOST **CONCERNED** about _____

My **CURRENT SYMPTOMS** ARE [Check ALL THAT APPLY]

- ☐ Abdominal pain
- ☐ Acne
- ☐ Appetite decrease
- ☐ Appetite increase
- ☐ Back pain
- ☐ Belching
- ☐ Breast discharge
- ☐ Breast soreness
- ☐ Breast swelling
- ☐ Bruising easily
- ☐ Chest pain
- ☐ Cold sensitivity
- ☐ Constipation
- ☐ Cough
- ☐ Delivered _____ months ago
- ☐ Dental problems
- ☐ Depression
- ☐ Diarrhea
- ☐ Dizziness
- ☐ Erection problem
- ☐ Eye bulging
- ☐ Eye pain
- ☐ Fatigue
- ☐ Feet are Cold
- ☐ Flushed face
- ☐ Forgetfulness
- ☐ Gas Excess
- ☐ Hair excess on body
- ☐ Hair excess on face
- ☐ Hair fall off scalp
- ☐ Hand pain
- ☐ Headache
- ☐ Hearing loss
- ☐ Heart racing
- ☐ Heartburn
- ☐ Heat sensitivity
- ☐ Infertility - Inability to have children
- ☐ Joint pain
- ☐ Joint swelling
- ☐ Leg pain
- ☐ Leg swelling
- ☐ Nail abnormality
- ☐ Nausea
- ☐ Neck swelling
- ☐ Nervousness
- ☐ Numbness
- ☐ Nursing Currently
- ☐ Passing out
- ☐ Period disturbance
- ☐ Pregnant _____ weeks
- ☐ Seizure
- ☐ Sex drive decrease
- ☐ Skin rash
- ☐ Sleep difficulty
- ☐ Sleep excess
- ☐ Smell Loss
- ☐ Sores
- ☐ Sputum has blood
- ☐ Stiffness
- ☐ Swallowing difficulty
- ☐ Sweating
- ☐ Thirst
- ☐ Throat Sore
- ☐ Tingling
- ☐ Urination at nighttime
- ☐ Urination pain
- ☐ Urine frequency Increased
- ☐ Urine Incontinence - Inability to control urine
- ☐ Vision Blurred
- ☐ voice Hoarseness
- ☐ Vomiting
- ☐ Weight gain
- ☐ Weight loss
- ☐ Wheezing
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

DISEASES I Have *or* Had:

- **Diabetes** type _____
- Eye damage from sugar
- Kidney damage from sugar
- Nerve damage from sugar
- Abnormal **cholesterol**
- High **thyroid**
- Low thyroid
- Thyroid nodules
- Rheumatoid arthritis
- **Cancer** of _____
- Heart disease
- Hypertension
- Stroke
- Anxiety
- Depression
- Parathyroid excess
- High **calcium**
- Low calcium
- _____
- _____

Other: _____

SURGERIES I had:_____

MY FAMILY (Father, Mother, sister, brother, son, daughter) Has OR Had the following diseases:

Example: Disease: Diabetes Type 2 → Relation: Father

Disease	Relation	Disease	Relation

Endocrine Specialists, PC

Name: _____ DOB: _____ Date: _____

SOCIAL HISTORY:

ALCOHOL ☐ Never ☐ Drink Occasionally ☐ Drink Daily

SMOKING ☐ Never smoked ☐ Currently smoke ____ packs/day since the year of _____
☐ Used to smoke _____ packs/day for _____years, but quit since the year of _____

STREET DRUGS: ☐ Never used ☐ Still using _____ since the year of _____
☐ Used to use _____ for _____ years, but quit since the year_____

DRUG ALLERGIES: _____

MEDICATIONS: I currently use the following:

MEDICATION NAME (e.g. Aspirin)	STRENGTH (e.g. 81 mg)	TYPE (e.g. tablet)	MORNING	NOON	SUPPER	BEDTIME