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

Endocrine Specialists, PC
M. Moosa, MD

P: 734-682-5243 or 419-724-0004 | **F**: 888-677-1987 Call@EndoMDs.com www.EndoMDs.com

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 CANCELED OR DELAYED

Endocrine Specialists, PC

PATIENT REGISTRATION

PATIENT'S LAST NAME	**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 Number:	Whom may we thank for referring you?

ADDRESS Street	**FACILITY** you want to be seen at: ❑Monroe ❑Toledo ❑Oregon
Apt #	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)** Street
Is Guarantor an **Existing Patient** in our clinic?	Apt #
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 Number:	Email:

Endocrine Specialists, PC

PATIENT REGISTRATION

PRIMARY INSURANCE	SECONDARY INSURANCE
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 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 DOB

_____ _____

Signature Date

Endocrine Specialists, PC

Name: _____ DOB: _____ Date: _____

I am MOST **CONCERNED** about _____

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

- ☐ Acne L70.9
- ☐ Fatigue R53.82
- ☐ Feet are Cold
- ☐ Back pain
- ☐ Breast discharge
- ☐ Cold sensitivity
- ☐ Constipation
- ☐ Delivered on _____
- ☐ Depression
- ☐ Diarrhea
- ☐ Dizziness R42
- ☐ Erection problem F52.21
- ☐ Eye bulging
- ☐ Nausea
- ☐ Neck swelling
- ☐ Flushed face
- ☐ Hair excess on body L68.0
- ☐ Hair excess on face L68.0
- ☐ Hair fall off scalp L65.8
- ☐ Hand pain
- ☐ Headache
- ☐ Heart racing R00.2
- ☐ Heat sensitivity
- ☐ Infertility: Inability to have children N46.9/N97.9
- ☐ Leg pain
- ☐ Leg swelling
- ☐ Throat Sore
- ☐ Tingling
- ☐ Nervousness
- ☐ Numbness
- ☐ Nursing Currently
- ☐ Pregnant ___ weeks
- ☐ Seizure
- ☐ Sex drive decrease R68.82
- ☐ Sleep difficulty
- ☐ Sleep excess
- ☐ Sweating R61
- ☐ Swallowing difficulty R13.10
- ☐ Thirst
- ☐ Urination at nighttime
- ☐ Urine frequency Increased
- ☐ Vision Blurred
- ☐ Voice hoarseness R49.0
- ☐ Weight gain R63.5
- ☐ Weight loss R63.4
- ☐ _____
- ☐ _____
- ☐ _____

MEDICATIONS: I currently use the following:

MEDICATION NAME	STRENGTH	HOW MANY ARE YOU TAKING AND WHEN?

Endocrine Specialists, PC

Name: _____ DOB: _____ Date: _____

FAMILY MEMBERS (examples: Father, Mother, sister, brother, son, daughter) has OR had the following diseases:

Disease	Relation	Disease	Relation

DISEASES I Have *or* Had:

☐ **Diabetes** type _____ E10/11.65	☐ Loss of head **hair** L65.8	☐ **Osteoporosis** M81.0
☐ High **cholesterol** E78.5	☐ Excessive Facial/body hair L68.0	☐ Osteopenia M85.80
☐ Nerve damage from sugar E10/11.40	☐ Hirsutism L68.0	☐ Low **calcium** in blood E83.51
☐ Kidney damage from sugar E10/11.21	☐ Acne L70.9	☐ High calcium in blood E83.52
☐ Eye damage from sugar E10/11.39	☐ PCOS E28.2	☐ High calcium in urine E83.50
☐ Renal dysfunction N18.9	☐ Female inability to conceive N97.9	☐ Parathyroid excess E21.3
☐ Prediabetes R73.03	☐ Menopause N95.1	☐ Low vitamin D E55.9
☐ Insulin resistance E88.81	☐ Low **testosterone** E29.1	☐ High **potassium** E87.5
☐ Low **thyroid** E03.9	☐ Erectile dysfunction F52.21	☐ Low potassium E87.6
☐ High thyroid E05.90	☐ Male inability to conceive N46.9	☐ Low magnesium E83.42
☐ Thyroid nodules E04.2	☐ Delayed puberty E30.0	
☐ Goiter E04.9	☐ Precocious puberty E30.1	
☐ Hashimoto's thyroiditis E06.3	☐ **Pituitary** tumor D44.3	☐ **Heart** disease I51.9
☐ Chronic **fatigue** R53.82	☐ **Adrenal** insufficiency E27.40	☐ High blood pressure I10
	☐ Adrenal tumor D44.10	☐ Atrial fibrillation I48.91
☐ **Depression** F33.9		☐ **COPD** J44.9
☐ Anxiety F41.9		☐ Asthma J45.909
☐ ADHD F90.9		☐ Sleep apnea G47.30
☐ Migraines G43.909	☐ Acid reflux (**GERD**) K21.9	☐ **Cancer** of _____
☐ Mental disability F79	☐ Irritable bowel syndrome K58.9	☐ Gout M10.9
☐ Seizures G40.909	☐ **Anemia** D64.9 or D50.9	☐ Cataract H25.9
☐ Stroke I63.9	☐ Iron deficiency E61.1	☐ Allergies T78.40

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_____

SURGERIES I had:_____

_____

DRUG ALLERGIES: _____