

15506 S. Telegraph Road, **Monroe, MI 48161**
3156 Dustin Road #301, **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
- 3156 Dustin Rd. #301, 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***

PATIENT REGISTRATION

PATIENT'S LAST NAME	APPOINTMENT CONFIRMATION
First name:	<input type="checkbox"/> Phone <input type="checkbox"/> Text
Middle Initial:	Assigned Physician you want to see in our clinic: <input type="checkbox"/> Dr. Moosa <input type="checkbox"/> _____
Date Of Birth:	Referring Physician:
Sex/Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> _____	Referring Physician Phone:
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> _____	Primary Care Physician:
Social Security Number:	Primary Care Physician Phone:
ADDRESS	Whom may we thank for referring you?
Street	FACILITY you want to be seen at:
Apt #	<input type="checkbox"/> Monroe <input type="checkbox"/> Toledo <input type="checkbox"/> Oregon
Zip	Employer's Name:
City	Employer's Phone:
State	Pharmacy Name/Location:
HOME PHONE	Pharmacy Phone:
Mobile Phone:	Nickname:
Work Phone:	Language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> French <input type="checkbox"/> _____
Email:	Race:
Communication - Best Way to contact you: <input type="checkbox"/> Home Ph <input type="checkbox"/> Mobile Ph <input type="checkbox"/> Work Ph <input type="checkbox"/> Email	Ethnicity: <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic
Emergency Contact Name:	Smoking: <input type="checkbox"/> Currently Daily <input type="checkbox"/> Currently Some Days <input type="checkbox"/> Former <input type="checkbox"/> Never
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?	Street
Relationship to Patient:	Apt #
Guarantor's last name:	City
First name:	State
Middle Initial:	Zip
Date of Birth:	GUARANTOR'S HOME PHONE (if different from Patient)
Sex:	Mobile Phone:
Social Security Number:	Work Phone:
	Email:

Endocrine Specialists, PC

Name: _____ DOB: _____ Date: _____

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

Disease	Relation	Disease	Relation

DISEASES I Have or Had:

<input type="checkbox"/> Diabetes type _____ E10/11.65	<input type="checkbox"/> Loss of head hair L65.8	<input type="checkbox"/> Osteoporosis M81.0
<input type="checkbox"/> High cholesterol E78.5	<input type="checkbox"/> Excessive Facial/body hair L68.0	<input type="checkbox"/> Osteopenia M85.80
<input type="checkbox"/> Nerve damage from sugar E10/11.40	<input type="checkbox"/> Acne L70.9	<input type="checkbox"/> Low calcium in blood E83.51
<input type="checkbox"/> Kidney damage from sugar E10/11.21	<input type="checkbox"/> PCOS E28.2	<input type="checkbox"/> High calcium in blood E83.52
<input type="checkbox"/> Eye damage from sugar E10/11.39	<input type="checkbox"/> Female inability to conceive N97.9	<input type="checkbox"/> High calcium in urine E83.50
<input type="checkbox"/> Renal dysfunction N18.9	<input type="checkbox"/> Menopause N95.1	<input type="checkbox"/> Parathyroid excess E21.3
<input type="checkbox"/> Prediabetes R73.03	<input type="checkbox"/> Low testosterone E29.1	<input type="checkbox"/> Low vitamin D E55.9
<input type="checkbox"/> Insulin resistance E88.81	<input type="checkbox"/> Erectile dysfunction F52.21	<input type="checkbox"/> High potassium E87.5
<input type="checkbox"/> Low thyroid E03.9	<input type="checkbox"/> Male inability to conceive N46.9	<input type="checkbox"/> Low potassium E87.6
<input type="checkbox"/> High thyroid E05.90	<input type="checkbox"/> Delayed puberty E30.0	<input type="checkbox"/> Low magnesium E83.42
<input type="checkbox"/> Thyroid nodules E04.2	<input type="checkbox"/> Precocious puberty E30.1	
<input type="checkbox"/> Goiter E04.0	<input type="checkbox"/> Hyperprolactinemia	
<input type="checkbox"/> Hashimoto's thyroiditis E06.3	<input type="checkbox"/> Pituitary tumor D44.3	<input type="checkbox"/> Heart disease I51.9
<input type="checkbox"/> Chronic fatigue R53.82	<input type="checkbox"/> Adrenal insufficiency E27.40	<input type="checkbox"/> High blood pressure I10
	<input type="checkbox"/> Adrenal tumor	<input type="checkbox"/> Atrial fibrillation I48.91
<input type="checkbox"/> Gender identity disorder F64.9	<input type="checkbox"/> D44.12 left-sided	<input type="checkbox"/> COPD J44.9
<input type="checkbox"/> Depression F33.9	<input type="checkbox"/> D44.11 right-sided	<input type="checkbox"/> Asthma J45.909
<input type="checkbox"/> Anxiety F41.9		<input type="checkbox"/> Sleep apnea G47.30
<input type="checkbox"/> ADHD F90.9	<input type="checkbox"/> Acid reflux (GERD) K21.9	<input type="checkbox"/> Cancer of _____
<input type="checkbox"/> Migraines G43.909	<input type="checkbox"/> Irritable bowel syndrome K58.9	<input type="checkbox"/> Gout M10.9
<input type="checkbox"/> Seizures G40.909	<input type="checkbox"/> Anemia D64.9 or D50.9	<input type="checkbox"/> Cataract H25.9
<input type="checkbox"/> Stroke I63.9	<input type="checkbox"/> Iron deficiency E61.1	<input type="checkbox"/> Allergies T78.40

SOCIAL HISTORY:

ALCOHOL Never Drink Occasionally Drink Daily
 Used to drink for _____ years, but quit since the year _____

SMOKING Never smoked Currently smoke _____ packs/day since the year _____
 Used to smoke _____ packs/day for _____ years, but quit since the year _____

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

SURGERIES I had: _____

DRUG ALLERGIES: _____