

Endocrine Specialists, PC

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15506 S Telegraph Rd, **Monroe, MI 48161**

6855 Spring Valley #150, **Holland OH 43528**

2702 Navarre Ave. Suite 106, **Oregon, OH 43616**

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***

PATIENT REGISTRATION

PATIENT LAST NAME:	Preferred Appointment Confirmation – <input type="checkbox"/> Phone <input type="checkbox"/> Text
FIRST NAME:	Assigned Physician you want to see in our clinic: <input type="checkbox"/> Dr. Moosa <input type="checkbox"/> _____
Middle Initial:	Referring Physician:
Date Of Birth:	Referring Physician Phone:
Sex/Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> _____	Primary Care Physician:
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> _____	Primary Care Physician Phone:
SOCIAL SECURITY NO.:	Whom may we thank for referring you?
FULL MAILING ADDRESS :	FACILITY you want to be seen: <input type="checkbox"/> Monroe <input type="checkbox"/> Holland <input type="checkbox"/> Oregon
Address	Employer's Name:
Zip	Employer's Phone:
City	Pharmacy Name/Location:
State	Pharmacy Phone:
HOME PHONE:	Nickname:
MOBILE PHONE:	Language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> French <input type="checkbox"/> _____
WORK PHONE:	Race:
EMAIL:	Ethnicity: <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic
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	Smoking: <input type="checkbox"/> Currently Daily <input type="checkbox"/> Currently Some Days <input type="checkbox"/> Former <input type="checkbox"/> 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

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

Name: _____ DOB: _____ Date: _____

I am **MOST CONCERNED** about _____

My CURRENT SYMPTOMS ARE [Check ALL THAT APPLY]

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

DISEASES I Have or Had:

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

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

