Welcome To Endocrine Specialists, PC

Tel: 734-682-5243 or 419-724-0004 ● Fax: 888-677-1987
Email: Call@EndoMDs.com ● Website: EndoMDs.com

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Your appointment is on _____ at _____ am/pm in the following location:

- □ **15506 S. Telegraph Rd, Monroe, MI 48161**
- □ **6855 Spring Valley Dr. #150, Holland, OH 43528**
- □ **3156 Dustin Rd. #301, Oregon, OH 43616**

Please expect your visit to take 1-2 hours

Patient Instructions:

1. Bring completed NEW PATIENT PACKET
2. Bring PHOTO ID AND INSURANCE CARDS
3. Bring COPAY (all co-pays and past due balances are due at time of service)
4. Bring your SUGAR NUMBERS if diabetic
5. Have your referring physician send us your RECENT TEST RESULTS

Cancellation Policy:

Please notify our office as soon as possible if you need to cancel or reschedule an appointment. Missing, canceling, or rescheduling a total of five (5) appointments in a year OR missing/cancelling three (3) appointments in a row may be cause for discharge from our practice.

Afterhours Contact:

If you have an EMERGENCY, please dial 911 or go to the nearest ER or urgent care as we do not have a physician on call after hours. Otherwise, please call during normal business hours and expect a response within two (2) business days.

Prescription Refills:

Allow up to three (3) business days for all refills. You may need to schedule an appointment before a refill is authorized if you are due to return.

Test Results:

We generally order tests to be done shortly before the next visit, to be discussed during the next visit. Except in unusual situations, test results are not discussed over the phone to avoid miscommunication.

During your next follow up visit, we will:

- Give you copies of test results
- Discuss results
- Make our recommendations

You may also request copies of your test results by signing a record release form. Please allow 3-14 days for test results to reach us.

Reasons for Discharge from Our Practice:

- Noncompliance or lack of cooperation with our recommended treatment plan
- Threats of violence toward providers, staff, or other patients
- Inappropriate sexual advances toward providers, staff, or other patients
- Disruptive or uncivil behavior toward providers, staff, or other patients
- Providing false or misleading medical history
- Demands for: inappropriate treatments or medications, advice or treatment outside our area of expertise, advice or treatment at a location other than our practice locations
- Repeated failure to keep appointments, or failure to reply to our messages, or failure to pay bills

Welcome to our practice and thank you for choosing Endocrine Specialists for all of your endocrine health care needs.

Please keep this page for your records.

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

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) have 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	☐ Acne L70.9	☐ Low **calcium** in blood E83.51
☐ Kidney damage from sugar E10/11.21	☐ PCOS E28.2	☐ High calcium in blood E83.52
☐ Eye damage from sugar E10/11.39	☐ Female inability to conceive N97.9	☐ High calcium in urine E83.50
☐ Renal dysfunction N18.9	☐ Menopause N95.1	☐ Parathyroid excess E21.3
☐ Prediabetes R73.03	☐ Low **testosterone** E29.1	☐ Low vitamin D E55.9
☐ Insulin resistance E88.81	☐ Erectile dysfunction F52.21	☐ High **potassium** E87.5
☐ Low **thyroid** E03.9	☐ Male inability to conceive N46.9	☐ Low potassium E87.6
☐ High thyroid E05.90	☐ Delayed puberty E30.0	☐ Low magnesium E83.42
☐ Thyroid nodules E04.2	☐ Precocious puberty E30.1	
☐ Goiter E04.0	☐ Hyperprolactinemia	
☐ 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	☐ Atrial fibrillation I48.91
☐ Gender identity disorder F64.9	☐ D44.12 left-sided	☐ **COPD** J44.9
☐ **Depression** F33.9	☐ D44.11 right-sided	☐ Asthma J45.909
☐ Anxiety F41.9		☐ Sleep apnea G47.30
☐ ADHD F90.9	☐ Acid reflux (**GERD**) K21.9	☐ **Cancer** of _____
☐ Migraines G43.909	☐ 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
☐ 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: _____