(1)

Florida Center for Endocrinology PA
Veena Patil, MD.

6001 Vineland Road, Suite 111
Orlando, FL 32819

Phone: 407-250-6770
Fax: 407-278-1600

NEW PATIENT HISTORY FORM

Name (Last, First, Middle): _____ Age: _____Sex:____
DOB: _____

Referring Physician Name/Address/Phone #

_____
_____
_____
_____
_____

Primary Care Name/Address/Phone #

_____
_____
_____
_____
_____

Please specify the reason(s) you are coming to this clinic:

_____
_____
_____
_____
_____

Past Medical History: Check if you ever had any of the following conditions:

- ○ Diabetes
- ○ High Blood Pressure
- ○ High Cholesterol
- ○ Chest Pain/Angina
- ○ Heart Attack
- ○ Heart Failure
- ○ Irregular Heart Rhythm
- ○ Stroke
- ○ Liver Disease
- ○ Kidney Disease
- ○ Thyroid Disease
- ○ Osteoporosis
- ○ Kidney Stones
- ○ Stomach Ulcers
- ○ Heart Burn
- ○ PCOS
- ○ Adrenal Disease
- ○ Pituitary Disease
- ○ Anxiety Depression
- ○ Asthma
- ○ Cancer
- ○ COPD

Please list any other medical problems:

_____
_____
_____
_____
_____

Please list all surgeries and year when took place:

_____
_____
_____
_____
_____

Women only:

How old were you when you had your first menstrual cycle? _____

What was the date of your last menstrual cycle? _____

How many periods do you have a year? _____

Have you gone through menopause? _____ If yes, what age?

_____

How many times have you been pregnant? _____

How many children do you have? _____

How many miscarriages have you had? _____

Do you currently use a method to prevent pregnancy? _____ If yes, what method? _____

Allergies

List any allergies to medication and type of reaction:

_____
_____
_____
_____
_____

Family History: Do you have relatives with any of the following conditions:

	Yes	No	Relation to you
Diabetes			
High Blood Pressure			
High Cholesterol			
Heart Disease			
Stroke			
Thyroid Disease			
Osteoporosis			
Kidney Stones			
Calcium Disorder			
Pituitary Disorder			
Cancer			

Any other medical conditions in the family?

_____

_____

_____

Social History

What is your marital status?

O Single O Married O Divorced O Separated O Widowed O In relationship

How many children do you have? _____

Sexual Orientation: _____

What is your occupation? _____

Gender Identity: _____

Do you exercise daily? _____

Number of times a week: _____

Do you smoke cigarettes? _____

If yes, # packs/day? _____

Number of years you have

Been smoking? _____

Not currently but I smoked in the past

Quit date: _____

# of packs/day? _____

 # years you smoked? _____

Do you drink alcohol?

O Yes O No

Number of drinks/day _____

Type of alcohol _____

Do you use recreational or street drugs?

O Yes O No O Not currently, but did in past

Quit date: _____

Have you ever given yourself street drugs with a needle?

O Yes O No

Check any of the following symptoms you might have been experiencing on a regular basis:

- ○ Fever
- ○ Weight Loss
- ○ Weight Gain
- ○ Fatigue
- ○ Excessive thirst
- ○ Feeling excessively hot
- ○ Feeling excessively cold
- ○ Excessive sweating
- ○ Light headedness

- ○ Blurred Vision
- ○ Double vision
- ○ Tunnel vision
- ○ Bulging eyes
- ○ Dry eyes

- ○ Dental problems
- ○ Hoarseness of voice/change in voice
- ○ Neck swelling
- ○ Swollen neck glands

- ○ Chest pain
- ○ Heart racing/palpitations
- ○ Leg swelling
- ○ Breast tenderness
- ○ Fluid leakage from breast
- ○ Breast lump/engorgement
- ○ Excessive urination
- ○ Waking at night to urinate
- ○ Weak urine stream

For men only:

- ○ Difficulty with erections
- ○ Low sexual desires

- ○ Abdominal pain
- ○ Heart burn
- ○ Nausea
- ○ Vomiting
- ○ Diarrhea
- ○ Constipation

- ○ Headaches
- ○ Tremors
- ○ Numbness/tingling in fingers and toes or any part of body

- ○ Joint aches
- ○ Muscle aches
- ○ Loss of height
- ○ Back pain

- ○ Change in ring size
- ○ Change in shoe size
- ○ Skin rash
- ○ Dry skin
- ○ Hair loss
- ○ Excessive hair growth
- ○ Acne

- ○ Easy bruising/bleeding

- ○ Depressed mood
- ○ Excessive nervousness

For women only:

- ○ Irregular menstrual cycles
- ○ Unusual vaginal bleeding
- ○ Hot flashes
- ○ Low sexual desire

New Patient Registration Form

Last Name: _____ First Name: _____ MI: __
Preferred Name: _____ Gender: M F
DOB: _____ SSN# _____
Occupation: _____
Street Address: _____
City/State/Zip code: _____
Phone Home: _____ Work: _____ Cell: _____
Please circle preferred phone number
Is it okay to leave messages regarding appointments, results, etc. at this number? Y N
Email Address: _____
Is it okay to send messages about your health via email? Y N
How did you hear about the clinic? _____
Who should be contacted I case of an emergency?
Name: _____ Relationship: _____
Phone Home: _____ Work: _____ Cell: _____
Address: _____
Name: _____ Relationship: _____
Phone Home: _____ Work: _____ Cell: _____
Address: _____

Patient Insurance Information
(Please remember to bring your insurance card to your appointment)

Name of Primary Insurance Company: _____
ID/Policy #: _____ Group #: _____ Co-pay Amount $_____
City/State/Zip: _____
Insurance Company Phone Number: _____
Subscriber's Full Name: _____ DOB: _____
Subscriber's SSN: _____ Relation to Patient: _____
Subscriber's Address: _____
City/State/Zip: _____
Subscriber's Phone Number: _____
Subscriber's Employer Name: _____

Name of Secondary Insurance Company: _____
ID/Policy #: _____ Group #: _____ Co-pay Amount $_____
City/State/Zip: _____
Insurance Company Phone Number: _____
Subscriber's Full Name: _____ DOB: _____
Subscriber's SSN: _____ Relation to Patient: _____
Subscriber's Address: _____
City/State/Zip: _____
Subscriber's Phone Number: _____
Subscriber's Employer Name: _____

Medications: List all current medications

Name of Medication	Dose	Frequency

Patient Signature: _____

Print Name: _____

Date: _____

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Florida Center for Endocrinology PA **Veena Patil, MD**

6001 Vineland Road Suite 111, Orlando, FL 32819

Phone: 407-250-6770 Fax: 407-278-1600

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize _____ to release healthcare information of the patient named above to:

Name: Florida Center for Endocrinology PA/Veena Patil, MD

Address: 6001 Vineland Road Suite 111

City: Orlando State: FL Zip Code: 32819

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: _____

_____

☐ All healthcare information:

- Labs:
- Ultrasound/Radiology:
- Medication List:
- Recent progress notes:

☐ Other: _____

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDs (Acquired Immunodeficiency Syndrome), and gonorrhea.

☐ Yes ☐ No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these results to anyone.

☐ Yes ☐ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature: _____ **Date Signed:** _____

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.

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Phone: 407-250-6770 Fax: 407-278-1600

Payment Policy:
Thank you for choosing us as your Endocrine specialty provider. We are committed to providing you with quality and affordable health care. Because some of our patients have ha questions regarding patient and insurance responsibility for service rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you may have, and sign in the space provided to you upon request.

1. **Insurance.** We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected as each visit. If you are insured by a plan we do business with, but don't have an up to date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.
2. **Co-payments and deductibles.** All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.
3. **Non-covered services.** Please be aware that some – and perhaps all – of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.
4. **Proof of Insurance.** All patients must complete our patient information form before being seen by the doctor. We must obtain a copy of your driver's license and current valid insurance to provide manner, you may be responsible for the balance of a claim.
5. **Claims submission.** We will submit your claims and assist you in any way we reasonably can to help you get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.
6. **Coverage changes.** If your insurance changes please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.
7. **Nonpayment.** If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.
8. **Missed appointments.** If there are two cancelled appointments in a row, regardless of how much notice was given, there will be a $25.00 cancellation fee applied to the patient's account. These charges will be your responsibility and billed directly to you. Rescheduled appointments are considered a cancellation.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

Print Name: _____
Signature of patient or responsible party: _____

Patient Authorization for Use and Disclosure of Protected Health Information (PHI) from the Practice:

By signing this form, I authorize Florida Center for Endocrinology PA to use and/or disclose certain PHI about me to the contact listed:

_____ (Name)

_____ (Relationship)

_____ (Phone Number)

I would like the above named person to pick up medical items, including prescriptions, from the office if I am unable to: ___Yes ___ No

This authorization will expire: ___ Upon death or ___ specify date (__/__/____)

This authorization permits the practice to use and/or disclose the following identifiable health information about me:

___ All medical care needs

___ Other [If other, specifically describe the information to be used or disclosed; such as date(s) of service, level of detail to be released or origin of information: _____

_____

Our office may contact you with appointment and medical information through home phone, cell phone, work phone, email, patient portal, or with your HIPAA appointed person unless otherwise specified below: _____

_____

Emergency Contact Information (If contact is the same as above, please indicate by writing "Same as above" and include address and D.O.B.)

1. Name _____ _____

   D.O.B.: _____ Relationship:_____

   Street Address: _____ City/State/Zip: _____

   Home Phone: _____ Cell Phone: _____ Work Phone: _____

2. Name _____ _____

   D.O.B.: _____ Relationship:_____

   Street Address: _____ City/State/Zip: _____

   Home Phone: _____ Cell Phone: _____ Work Phone: _____

Patient Signature: _____ **Date:** _____

Florida Center for Endocrinology PA

Acknowledgement of Receipt of Notice of Privacy Practices

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practice with respect to protected health care information. If you have any objections to this form, please ask to speak with your clinician or HIPAA privacy officer in person or by phone: 407-250-6770.

By signing this below you are acknowledging that you have read the Notice of Privacy practices. If you need a copy please ask the office staff.

Print Name: _____

Signature: _____

Date: _____

Preventive Health Survey

For patient with diabetes:

Flu shot: _____ date

Pneumonia shot: _____ date

Last eye exam: _____date, Place: _____

Foot Exam by Podiatry: _____ date, Place: _____

Do you have any history of coronary artery disease: ____ Y ____ N

Do you have any history of stroke: ____ Y ____ N

Do you have any history of peripheral vascular disease: ____ Y ____ N

For all patients:

Pharmacy: _____

Address: _____

_____

Phone: _____ Fax: _____

Please provide your email for patient EHR chart access: _____

Name: _____

Race: _____ (Hispanic, non Hispanic)

Ethnicity: _____(Hispanic, Asian, American Indian, White, Black)