



NORTHEAST
ENDOCRINOLOGY
ASSOCIATES P.A.

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Patient Information Form

Please fill out the following information so we can update your chart.

Patient Name: _____, _____ Preferred Name
Last First

Social Security Number: ____ / ____ / ____ **Date of Birth:** ____ / ____ / ____ **Sex:** Male Female

Address: _____
Street City State Zip

Cell phone: _____ **Email:** _____

Race: Caucasian Asian African American Chinese Filipino Japanese
 Native American Native Hawaiian Pacific Islander Unknown Other _____

Preferred Language: English Spanish Vietnamese Other _____

Ethnicity: Hispanic or Latino Not Hispanic or Latino Unknown /Not Reported

EMERGENCY/HIPPA CONTACT

Name: _____ **Phone:** (____) ____ - ____ **Relation:** _____

Please check if: Authorized to release HIPPA Authorized to release financial information

INSURANCE INFORMATION

PRIMARY INSURANCE INFORMATION:

Name of Insurance: _____ Policy ID: _____

Group Number: _____ Group Employer: _____

Name of Policy Holder: _____ SSN#: ____ - ____ - ____ Date of Birth: ____ - ____ - ____

Policy Holder Relation to Patient: Self Spouse Child Other _____

SECONDARY INSURANCE INFORMATION:

Name of Insurance: _____ Policy ID: _____

Group Number: _____ Group Employer: _____

Name of Policy Holder: _____ SSN#: ____ - ____ - ____ Date of Birth: ____ - ____ - ____

Policy Holder Relation to Patient: Self Spouse Child Other _____

Preferred Pharmacy and phone number:

ASSIGNMENT OF BENEFIT: I hereby authorize payment directly to physician of benefits due to me for his/her services. I understand I am financially obligated for charges not covered by this authorization. I authorize the release of any medical or other information necessary to process this claim

Signature (Patient/Guardian): _____ Date ____ / ____ / ____



General Health Information

Welcome to our practice! Please take a moment to fill out the following health questions:

Patient Name: _____

Today's Date: ____ / ____ / ____

Preferred Name: _____

Prior medical problems - check all those that apply:

- | | | |
|--|--|--|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney stones | <input type="checkbox"/> Autoimmune Disease Type _____ |
| <input type="checkbox"/> Liver problems | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> High cholesterol |
| <input type="checkbox"/> Thyroid disease | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Depression |
| | | <input type="checkbox"/> Cancer |
| | | <input type="checkbox"/> Specify: _____ |

Prior surgeries - circle all those that apply, give dates if possible:

- | | |
|--|---|
| <input type="checkbox"/> Cancer ____ / ____ / ____ | <input type="checkbox"/> Thyroid Surgery ____ / ____ / ____ |
| <input type="checkbox"/> _____ ____ / ____ / ____ | <input type="checkbox"/> _____ ____ / ____ / ____ |
| <input type="checkbox"/> _____ ____ / ____ / ____ | <input type="checkbox"/> _____ ____ / ____ / ____ |

Do you use caffeine (coffee, tea, soda)? Yes No If yes, how many servings per day? _____

Do you drink alcoholic beverages such as wine, beer, or mixed drinks? Yes No
If yes, how many servings per day? _____

If you have ever used tobacco:

Tobacco Use: Current Former Never Type: cigarettes/cigars chewing tobacco snuff
 E-cigarettes

If YOU ARE DIABETIC:

Are you experiencing low blood sugars? Yes No

If yes, how many times per week? _____

How often do you check your blood sugar? _____

Have you had a recent eye exam? Yes No

Date of eye exam: ____ / ____ / ____

Eyes Dilated Yes No

Name of eye doctor: _____

Have you been told you have diabetic eye changes? Yes No

Physician List

Please include Primary Care Physician and Referring Physician

Please identify those MD's that records are to be requested from:

Medication List

Please take the time to fill out **all** the information

Name:

Dose/Mg:

Directions:

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Supplements or Vitamins:

Name:

Dose/Mg:

Directions:

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list all medications to which you are allergic:

Patient Name:

Date: