7323 N. 1604 E, Suite 601 * San Antonio, Texas 78233
210.650.3360 (office) • 210.650-3403 (fax)
www.neendocrinology.com

Patient Information Form

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

Patient Name: ________________________________, ________________________________ ____________________
Last First Preferred Name

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______________________________

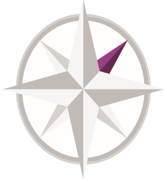
SECONDARY INSURANCE INFORMATION:
Name of Insurance: ____ Policy ID: ________________________________
Group Number: _____________________________ Group Employer: ______________________________________
Name of Policy Holder: _______________________ SSN#:_________________ Date of Birth: _______________
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________________



NORTHEAST ENDOCRINOLOGY ASSOCIATES P.A.

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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:*

☐ **Diabetes** ☐ **Kidney stones** ☐ **Autoimmune Disease Type** _______________

☐ **Liver problems** ☐ **High blood pressure** ☐ **High cholesterol** ☐ **Cancer**

☐ **Thyroid disease** ☐ **Osteoporosis** ☐ **Depression** ☐ **Specify:** _________________________

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

☐ **Cancer** ____________________ ☐ **Thyroid Surgery** ____________________

☐ ____________________ ☐ ____________________

☐ ____________________ ☐ ____________________

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:** ______________________________