FLORIDA ENDOCRINOLOGY & DIABETES CENTER

Thank you for choosing Florida Endocrinology and Diabetes Center! We are delighted to welcome you and will make every effort to service you in a manner that will meet your expectations.

Please assist us by completing the attached forms and bringing them with you for your initial visit.

If you need to change or cancel this appointment, please call the office your appointment is scheduled at (Please see “Addresses” section at the end of the page)

If your insurance requires authorization, please inform your primary care physician. If we do not receive an authorization for your appointment, it will be rescheduled.

Please bring the following items with you to your first appointment:

- Picture ID
- Insurance Card(s)
- Medication list
- Co-payment, if applicable
- Insulin Pump/Continuous Glucose Monitor, if applicable
- Two week record of blood sugars, if you are coming in for diabetes management

On behalf of our entire medical team, we would like to thank you for choosing us for your health-care needs.

ADDRESSES

Pinellas Park: 6229 66th St. N. Pinellas Park, FL 33781
Ph: 727-623-9913 l Fax: 727-803-6852
Saint Petersburg: 5775 5th Ave. N. St, Petersburg, FL 33710
Ph: 727-345-5222 l Fax: 727-345-4066
Tampa: 2835 W. DeLeon St. Ste. 102 Tampa, FL 33609
Ph: 813-359-0829 l Fax: 727-345-4066

Patient Information

Name: _____

Date of Birth: _____ SSN #: _____ Sex: ☐ Male ☐ Female

Address: _____ City: _____

State: _____ Zip: _____ Email: _____

Home Phone #: _____

Cell Phone #: _____

Marital Status:
- ☐ Married
- ☐ Single
- ☐ Divorced

Emergency Contact Name: _____

Relationship: _____ Emergency Contact Phone #: _____

Primary Care Physician (PCP) Name:

_____

Address/Office Location:

_____

PCP Phone #: _____

PCP Fax #: _____

Preferred Pharmacy: _____

Address: _____

Phone #: _____

Preferred Laboratory: _____

Address: _____

Phone #: _____

*To properly process your insurance claim, please complete below if the patient is NOT the **policy holder** on your insurance.*

Policy Holder's Name:

_____

Relationship to patient:

_____

Insured's Sex:
- ☐ Male
- ☐ Female

Insured's Date of Birth: _____

Insured's SSN #:

_____

Address: _____ City: _____

State: _____ Zip: _____ Phone #: _____

All information given is accurate. I give permission for Endocrine Associates to contact me regarding practice information by the above methods.

Signature: _____ Date: _____

Medications: Please list all medications you are currently taking:

Prescription Medication	Dose	How often you take it

Allergies: Please list any medication allergies you may have.

_____

_____

_____

Hospitalizations/Surgeries/Procedures:

1. _____
2. _____
3. _____
4. _____

Patient Medical History

Name: _____ Date of Birth: _____

Please circle all conditions you have or have had in the past:

Acromegaly	Anemia	Anxiety	Asthma	Autoimmune Disorder	Cancer: _____
Depression	Diabetes Type 1	Diabetes Type 2	Elevated Cholesterol/ Hyperlipidemia	Gastroparesis	GERD
CHF	Cirrhosis	COPD	Coronary Artery Disease	Crohn's Disease	Cushing's Disease
Hepatitis A	Hepatitis B	Hepatitis C	HIV	Hypercalcemia	Hypertension (High blood pressure)
Hyperthyroidism	Hypothyroidism	Hypoglycemia	Kidney Stones	Neuropathy	Osteoarthritis
Osteopenia	Osteoporosis	Peripheral Vascular Disease (PVD)	Pituitary Tumors	Retinopathy	Vascular Heart Disease
Rheumatoid Arthritis	Seizure Disorder	Stroke	Transient Ischemic Attack (TIA)	Thyroid Cancer	Thyroid Nodule

Other: _____

Social History:

Do you smoke or vape?	☐ Yes ☐ No	Packs/day: _____ Years _____ Quit date (if applicable): _____
Do you drink alcohol?	☐ Yes ☐ No	Drinks/week: _____ Quit date (if applicable): _____
Do you drink caffeine?	☐ Yes ☐ No	Cups/day: _____

Family History: Please check all that apply

☐ Unknown ☐ Adopted	Father	Mother	Brother	Sister	Maternal Grandfather	Maternal Grandmother	Paternal Grandfather	Paternal Grandmother
Anemia	☐	☐	☐	☐	☐	☐	☐	☐
Anxiety	☐	☐	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	☐	☐
Growth/ Developmental Disorder	☐	☐	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐	☐	☐
High Cholesterol	☐	☐	☐	☐	☐	☐	☐	☐
Hypertension	☐	☐	☐	☐	☐	☐	☐	☐
Hyperthyroidism	☐	☐	☐	☐	☐	☐	☐	☐
Hypothyroidism	☐	☐	☐	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐	☐	☐	☐	☐
Thyroid Nodules	☐	☐	☐	☐	☐	☐	☐	☐
Cancer: _____	☐	☐	☐	☐	☐	☐	☐	☐

Mother: ☐ Alive ☐ Deceased Age: _____

Father: ☐ Alive ☐ Deceased Age: _____

Siblings: Brothers: _____ Sisters: _____

Children: Boys: _____ Girls: _____

Review of Systems:

Cardiovascular

- ☐ Chest Pain
- ☐ History of irregular heart beat
- ☐ Palpitations
- ☐ History of poor circulation
- ☐ Leg swelling

Endocrine

- ☐ History of Diabetes
- ☐ Sensitive to hot or cold
- ☐ Excessive thirst
- ☐ Breast growth (men)

Eyes, Ears, Nose & Throat

- ☐ Blurred vision
- ☐ Double vision
- ☐ Bulging eyes
- ☐ Dry eyes
- ☐ Sinus problems
- ☐ Hoarseness

Gastrointestinal

- ☐ Constipation
- ☐ Diarrhea
- ☐ Vomiting
- ☐ Nausea
- ☐ Abdominal pain

General

- ☐ Weight gain
- ☐ Weight loss
- ☐ Fatigue

Lungs

- ☐ Shortness of breath
- ☐ Persistent cough
- ☐ Asthma or wheezing

Muscle, Joint, & Bone

- ☐ Swelling of ankles or legs
- ☐ Pain, weakness, or numbness in:
  Arms/hands
  Back/hips
  Legs/feet
  Neck or shoulders

Neurologic

- ☐ Burning pain in feet
- ☐ Numbness
- ☐ Tingling
- ☐ Frequent headache
- ☐ Tremor
- ☐ History of stroke
- ☐ Blackouts or loss of consciousness

Skin

- ☐ Skin ulcer
- ☐ Excessive dry skin
- ☐ Excessive hair growth

Urinary

- ☐ Difficulty urinating
- ☐ Urination at night
- ☐ Poor libido

Diabetic Questionnaire: Please fill out/circle each question.
If you are not diabetic, please skip.

1. In what year were you diagnosed with diabetes? _____
2. Have you ever been hospitalized for Diabetic Ketoacidosis (DKS)? Yes / No
3. Do you have a home glucose monitor? Yes / No
    a. Which monitor do you use _____
    b. How old is the monitor? _____
4. How often do you check your blood glucose? _____ / day
5. What is your typical glucose reading?
    a. Breakfast: _____
    b. Lunch: _____
    c. Dinner: _____
    d. Bedtime: _____
6. Have you ever experienced symptoms of low blood sugar? Yes / No
7. Do you measure your blood glucose level when you get these symptoms? Yes / No
    a. If yes, at what blood glucose level when you get these symptoms? _____
8. Have you ever been unconscious because of low blood sugar? Yes / No
9. Do you have any emergency glucagon (injection) kit? Yes / No
10. Has diabetes affected your eyes? Yes / No
    a. Date of last ophthalmology (eye) appointment: _____
11. To the best of your knowledge, has diabetes affected your kidney? Yes / No
12. Do you experience the following?
    a. Tingling in your hands/feet: Yes / No
    b. Vomiting: Yes / No
    c. Lightheadedness: Yes / No
    d. Diarrhea: Yes / No
    e. Weight loss: Yes / No
13. If you are on insulin, where do you give injections?
    - ☐ Abdomen
    - ☐ Arms
    - ☐ Legs
    - ☐ Buttocks
14. Have you ever attended diabetes teaching classes? Yes / No
    a. Where and how long ago? _____
15. Have you met with a dietician? Yes / No
    a. Where and how long ago? _____
16. How has your weight changed over the past year?: _____
17. Do you exercise regularly? Yes / No
    a. What type of exercise? _____
18. (Females) If you have been pregnant, were you a diabetic during pregnancy? Yes / No
    a. Do you currently use birth control? Yes / No

Authorization to Release Patient Health Information

Name: _____ Date of Birth: _____

I authorize and request the following organization(s) to release information as stated below from the patient health information record:

Information Requested FROM:	**Information Released TO:**
Diabetes, Thyroid & Endocrinology Associates Other: _____	☐ Self ☐ Diabetes, Thyroid & Endocrinology Associates
Name: _____ Phone: _____ Fax: _____	
Name: _____ Phone: _____ Fax: _____	
Name: _____ Phone: _____ Fax: _____	

Information to be Released:

☐ Diagnostic Imaging	☐ All	☐ From Date(s): _____
☐ Lab Results	☐ All	☐ From Date(s): _____
☐ Progress Notes	☐ All	☐ From Date(s): _____
☐ Other, please specify: _____		
☐ Entire Medical Record. No limitations placed on dates, diagnoses, or treatments.		

_____ _____

Patient Signature or Signature of Authorized Representative of Patient **Date**

Patient Information & Financial Responsibilities

We appreciate that you have trusted us with your healthcare. Because healthcare benefits and coverage options have become increasingly complex, we have developed this policy which details our financial requirements, to help you better understand your responsibilities as a patient.

It is your responsibility to know if your insurance has specific rules or regulations, such as the need for referrals, pre-certifications, prior authorizations, limits on outpatient charges, and specific physicians and/or networks to use. You should be knowledgeable of any deductibles, copayments, and/or co-insurance. This applies to all payoffs regardless of whether our physician participates.

The responsibility for payment of fees for services is the direct responsibility of the patient. Your health benefit plan is an arrangement between you, the enrollee, and the insurance company, HMO, or your employer. Your health benefit plan determines your coverage, requirements, and establishes the limit on your coverage for medical services based on what they determine as medically necessary. However, we will do our best to assist you with understanding your proposed treatment and in answering questions related to your insurance.

Please make checks payable to: Florida Endocrinology and Diabetes Center

In an effort to provide excellent care to our patients, we are requesting the courtesy of a phone call if you are unable to make your appointment. Please notify the office at least 24 hours in advance if you need to cancel or reschedule your appointment. We thank you for your consideration of other patients who may need your appointment slot. I understand that if I do not give a 24 hour courtesy call to cancel or reschedule my appointment, I may be charged a fee of $25 – **INITIAL HERE_____**

Should you have any question with regard to our policies we encourage you to ask. It is our goal, not only to provide you with the best quality of medical care, but to help you by answering any insurance questions you may have.

I have read the above and agree:

Signature_____Date_____

Florida Endocrinology and Diabetes Center

HIPAA QUESTIONNAIRE

Patient Name: _____ Date of Birth: _____

1. Please list the family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment and health care operations).

   Name: _____ Relationship: _____ Date of Birth: _____

   Name: _____ Relationship: _____ Date of Birth: _____

2. Please list the family members or significant others, if any, whom we may inform about your medical condition ONLY IN AN EMERGENCY:

   Name: _____ Relationship: _____ Date of Birth: _____

   Name: _____ Relationship: _____ Date of Birth: _____

3. Please print the address of where you would like your postcards and/or correspondence from our office to be sent if other than your home.

   _____

4. Please print the telephone number where you want to receive calls about your appointments, lab and x-ray results, other health care information if other than your home phone number:

   _____

   I am fully aware that a cell phone is not a secure and private line.

5. Can confidential messages be left on your telephone answering machine?

   ☐ Yes ☐ No

   I am fully aware my health information will/may be transmitted by electronic transmission, by secure fax transmittal, by internet or by email for continued health care needs.

_____ Date: _____
Patient Signature