Personal Information **East Valley Endocrinology**

Last Name First Name		Date of Birth	Social Security Number
Address	City	State	Zip code
Home Phone	Cell Phone	Business Phone	
E-mail	*Please initial below to give us permission to contact you by email.		
_____ _____		_____ Yes, I give permission.	
Marital Status:		Gender:	
___ Married ___ Single ___ Divorced ___ Widowed ___ Separated		___ Male ___ Female	

Insurance Information (Must be filled out completely for verification purposes) **___ Check here if you have NO insurance**

Primary Insurance Company	Policyholder Name	Policyholder DOB	Patient relationship to insured
Policy #	Group #		
Secondary Insurance Company	Policyholder name	Policyholder DOB	Patient relationship to insured
Policy #	Group #		
We are required to ask this question about your race: ___ White or Caucasian ___ Hispanic or Latino ___ Black Hispanic or Latino ___ Black or African American ___ American Indian or Alaska Native ___ Native Hawaiian or Other Pacific Islander ___ Asian ___ Other ___ I prefer not to answer			

Authorization to disclose health information:

I authorize the release and/or discussion of my health information with the following persons.
Name_____ Relationship_____ Phone Number_____
Name_____ Relationship_____ Phone Number_____
Name_____ Relationship_____ Phone Number_____
____ Do not discuss my information with anyone.

Pharmacy

Name of Pharmacy	Address	Phone Number

Emergency Contact

Name	Relationship	Phone Number

I declare that the above answers and statements are true and correct to the best of my knowledge. I hereby acknowledge that I have read this entire section front and reverse, and agree to all of the terms herein.

X_____ _____

Signature of patient, responsible party Date

New patients: Please indicate how you heard about us. Thank you!
____ Physician ____ Friend ____ Word of mouth ____ Insurance Company ____ Internet ____ Other:

East Valley Endocrinology

9500 E. Ironwood Square Drive #201 Scottsdale, AZ 85258

Patient Financial Responsibility/HIPPA Notification/Disclosures

Patient Name:_____ Date of Birth:_____

____I. Financial Policy

This is a statement of East Valley Endocrinology's financial policy. You understand that you are obligated to ensure that our fees are paid in full. We will verify your coverage and bill your insurance carrier on your behalf. You agree that you will pay any deductible, co-payment, and/or co-insurance as determined by your insurance plan. Those payments will be due at the time of your service. Many insurance companies have additional requirements or stipulations that may affect your coverage. You are responsible for any amounts not covered or payable by your insurance. If your insurance denies any part of your claim, you agree to be responsible to pay the full balance. Non-payment of balances may be turned over to collections or small claims court for action.

____II. No Show/Cancellation Policy

East Valley Endocrinology requires a *minimum* of **24-hour notice** from our patients when cancelling or rescheduling an appointment. Failure to cancel/reschedule before the 24 hour window may result in a **$40 FEE** per missed office visit (payable upon receipt of billing). Telephonic appointment reminders are made by automated service 2 days prior to your appointment. However, it is ultimately your responsibility to remember scheduled appointments. You may leave notice of cancellations/re-schedules via phone **480-664-8988**, but it must be at least 24 hours in advance of the appointment. Please assist us in maintaining good service through efficiency. After 3 no-show appointments, the practice may choose to discontinue your care.

____III. HIPPA (Health Insurance Portability and Accountability Act of 1996)

We disclose your protected health information to carry out treatment, payment, and health care operations. If you would like a more detailed description of such uses and disclosures, please refer to the *Notice of Privacy Practices*. You have the right to review the *Notice of Privacy Practices* before signing this consent form. The terms of the *Notice of Privacy Practices* may change from time to time. You can get a copy of the latest *Notice of Privacy Practices* by contacting our office. We will also post a copy of our current *Notice of Privacy Practices* in our office. You have the right to request that we restrict how we use or disclose protected health information to carry out treatment, payment, or health care operations. We do not have to agree with such requests, but must honor the requests to which we agree. You have the right to revoke this consent in writing, and the revocation will become effective except to the extent that we acted in reliance on your consent.

____ IV. Self Pay

Self pay/non-insurance patients are expected to pay for office visits/labs/exams in full at the time of service. If you are unable to pay the amount in full, you must speak to the office manager.

____V. Referrals/Authorizations

It is the patient's responsibility to ensure that referrals are received from the referring physician and kept current. All AHCCCS and most HMO plans require a referral. For procedures, many insurances require authorizations.

____VI. Walk Ins

We do not take walk-ins. You must have an appointment, unless it is an emergency.

____VII. Refills

If you need a refill, you must have your pharmacy fax a request. Allow 3-5 business days. Request refills at least a week before you run out.

____VIII. Medical Records

There is a $25.00 reproduction fee for all records unless forwarded to another physician.

My Acknowledgement: I have read and understand the office policies described above. I agree to pay promptly and in full any amounts due to the provider including, co-payments, deductibles, and amounts due for non-covered or services that are not payable by my insurance. I assign all insurance benefits to East Valley Endocrinology and authorize use of my signature on all insurance submissions. I authorize and consent for the performance of office procedures deemed necessary by the physicians and their staff.

X_____ _____

Patient or legally authorized individual signature Date

HISTORY FORM

East Valley Endocrinology

Name: _____ Date of birth ___/___/___ Today's Date: ___/___/___

Referring Physician: _____ Phone Number _____

Reason for Visit: _____

PAST OR PRESENT MEDICAL CONDITIONS

☐ None

- ☐ Diabetes Type 1
- ☐ Diabetes Type 2
- ☐ Impaired Fasting Glucose
- ☐ Hypoglycemia
- ☐ Hypothyroid
- ☐ Hyperthyroid
- ☐ Thyroid cancer
- ☐ Cushings Syndrome
- ☐ Addisons Disease
- ☐ Blood clotting problems
- ☐ Dialysis
- ☐ Kidney disease
- ☐ Convulsions/Seizures
- ☐ Stroke
- ☐ Anxiety/Depression
- ☐ Bipolar/Schizophrenia
- ☐ Chronic pain
- ☐ Chronic headaches
- ☐ Colon cancer
- ☐ Ovarian cancer
- ☐ Lung cancer
- ☐ Breast cancer
- ☐ Prostate cancer
- ☐ Cervical/Uterine cancer
- ☐ Kidney cancer
- ☐ Fibromyalgia
- ☐ Skin cancer
- ☐ Thyroid disease
- ☐ Osteoporosis
- ☐ Diabetes
- ☐ High blood pressure
- ☐ COPD/Emphysema
- ☐ Heart attack
- ☐ Cardiac arrhythmia
- ☐ Heart stents
- ☐ Pace maker/Defibrillator

- ☐ Pancreatitis
- ☐ Celiac disease
- ☐ Crohn's disease
- ☐ Ulcerative colitis
- ☐ Gallstones
- ☐ Cirrhosis of liver
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ Other liver disease
- ☐ Diverticulitis
- ☐ Diverticulosis
- ☐ Hemorrhoids
- ☐ Irritable bowel syndrome
- ☐ Abnormal Weight Loss
- ☐ Abnormal Weight Gain
- ☐ Sexual Difficulties
- ☐

Other: _____

PREVIOUS SURGERIES • PROCEDURES • HOSPITALIZATIONS **Please provide year**

☐ None

- ☐ Appendix removal
- ☐ Cardiac bypass
- ☐ Heart valve replacement
- ☐ Implanted defibrillator(ICD)
- ☐ Gastric bypass/Surgery
- ☐ Gall bladder removal
- ☐ Hysterectomy
- ☐ C-section
- ☐ Ovary removal
- ☐ Breast Surgery
- ☐ Joint surgery
- ☐ Thyroid Surgery
- ☐ Tonsil/Adenoid removal
- ☐ Colectomy
- ☐ Hernia
- ☐ Hysterectomy
- ☐ Prostate
- ☐ Tubal Ligation
- ☐ Cataract surgery
- ☐ Laparoscopy
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

Other: _____

REVIEW OF SYSTEMS Please indicate if your are experiencing, or have experienced in the last six (6) months

☐ None

Constitutional
- ☐ Weight gain, abnormal
- ☐ Weight loss, abnormal
- ☐ Fever

Ear Nose Mouth and Throat
- ☐ Change in vision
- ☐ Dry eyes
- ☐ Bleeding gums
- ☐ Hoarseness

Respiratory
- ☐ Chronic cough
- ☐ Shortness of breath

Cardiovascular
- ☐ Irregular heart beat
- ☐ Palpitations
- ☐ Passing out
- ☐ Angina/chest pressure
- ☐ Ankle swelling

Hematologic/Lymphatic
- ☐ Prolonged bleeding
- ☐ Easy bruising
- ☐ Enlarged glands

Integumentary
- ☐ Itching
- ☐ Rashes

Musculoskeletal
- ☐ Back pain
- ☐ Joint pain
- ☐ Muscle pain

Neurological
- ☐ Seizures
- ☐ Headaches
- ☐ Stroke or paralysis

Endocrine
- ☐ Excessive thirst
- ☐ Cold intolerance

Psychiatric
- ☐ Anxiety
- ☐ Depression
- ☐ Attention deficit

Genitourinary
- ☐ Blood in urine
- ☐ Urinary incontinence
- ☐ Urinary infections

Gastrointestinal
- ☐ Milk intolerance
- ☐ Loss of appetite
- ☐ Painful swallowing
- ☐ Trouble swallowing
- ☐ Choking on swallowing
- ☐ Acid taste
- ☐ Regurgitation of food
- ☐ Heart burn
- ☐ Abdominal pain
- ☐ Hot Flashes
- ☐ Insomnia
- ☐ Jaundice
- ☐ Nausea
- ☐ Vomiting
- ☐ Blood in stool
- ☐ Black stool
- ☐ Rectal pain
- ☐ Pain in eyes
- ☐ Dry eyes
- ☐ Memory loss or confusion
- ☐ Hair loss/falling out
- ☐ Wheezing
- ☐ Change in skin color
- ☐ Change in nails
- ☐ Fatigue/Tired Feeling

NAME _____

ALLERGIES

☐ None	☐ Penicillin	☐ Gluten	☐ Codeine	Other Allergies:
	☐ Aspirin	☐ Eggs	☐ Propofol/Diprivan	_____
	☐ Sulfa	☐ Latex	☐ Demerol	
	☐ Tetracycline	☐ Nuts	☐ IV Contrast or Iodine	_____

MEDICATIONS Include vitamins and supplements

☐ None ☐ See my list ☐ I am on medication(s) but I don't remember their names

Medication's name	Strength	How Often	Medication's name	Strength	How Often

FAMILY HISTORY

☐ None

	Which family member		Which family member
Breast cancer	_____	Hypertension	_____
Stomach cancer	_____	Crohn's disease	_____
Pituitary Disorders	_____	Thyroid Cancer	_____
Colon cancer	_____	Diabetes	_____
Celiac disease	_____	Heart Disease	_____
Others	_____		

SOCIAL HISTORY

Alcohol Consumption ☐ None ☐ Every day ☐ Every week ☐ Every month ☐ Alcoholic ☐ Recovering Alcoholic

Tobacco ☐ Never smoked ☐ Current every day smoker ☐ Current some day smoker ☐ Former smoker

Recreational drug use ☐ No drug use ☐ Recreational drug use ☐ Past IV drug use ☐ Current IV drug use

Tattoos? Y or N Wears sunscreen? Y or N Wears seatbelt? Y or N Sexually active? Y or N Exercise at least 30 min/3x week? Y or N

OTHER PERTINENT MEDICAL INFORMATION

_____

_____ _____

Signature Date

_____ For office use _____

 Wgt: _____ Hgt: _____ BP: _____ P: _____

East Valley Endocrinology

Patient Assessment

Patient Name_____DOB _____

When was your last:	Date:	When was your last:	Date:
A1C		Mammogram	
Blood Glucose		Pap Smear	
Bone Density		Pneumonia vaccine	
Colonoscopy		Prostate Exam/PSA	
Dental Exam		Tdap vaccine	
Dilated Eye Exam		Chicken pox/Shingles vaccine	
Flu vaccine		EKG	
Foot exam		Thyroid ultrasound	
Lipid/cholesterol check		Complete physical exam	

Are you at risk for physical abuse? _____ Domestic violence? _____

Do you have any language or communication barriers? _____

Do you know the purpose and use of your medications?_____

How many falls (with injury) have you had in the past year? _____

How many falls (without injury) have you had in the past year? _____

Do you have days where you feel down or hopeless? _____ How often? _____

Do you have days that you have little interest in doing things? _____ How often? _____

For Women:

Last menstrual period _____ Frequency_____ Duration _____

What age did you get your period? _____ History of abnormal pap smears? _____

Pregnancy: Live births ____ Miscarriage ____ Stillbirths _____ Abortions_____ C-sections? _____

Any pre-term births? ____ History of ectopic pregnancy? _____ Highest birth weight of any baby? _____

Method of birth control_____ Menopause? ___ YES ____ NO

Patient Signature _____ Today's Date _____

East Valley Endocrinology

9500 E Ironwood Square Drive, #201 Scottsdale AZ 85258

480-664-8988 // fax 480-664-8998

List of Medical Providers

Patient _____ DOB _____

PCP/Family Physician _____ City/State _____

Phone Number _____ Fax Number _____

Please list ALL specialists (Nephrology,Ophthalmology,Podiatry, Cardiology, Neurology, Psychiatry, Pain, etc)

Specialist _____ Type of Specialist _____

Address _____ City _____ State _____

Phone Number _____ Fax Number _____

Specialist _____ Type of Specialist _____

Address _____ City _____ State _____

Phone Number _____ Fax Number _____

Specialist _____ Type of Specialist _____

Address _____ City _____ State _____

Phone Number _____ Fax Number _____

Specialist _____ Type of Specialist _____

Address _____ City _____ State _____

Phone Number _____ Fax Number _____

Specialist _____ Type of Specialist _____

Address _____ City _____ State _____

Phone Number _____ Fax Number _____

Specialist _____ Type of Specialist _____

Address _____ City _____ State _____

Phone Number _____ Fax Number _____

I give permission to release and/or request records from the above providers in order to provide a thorough medical history and assessment of progress. Signature _____ Date _____

East Valley Endocrinology, Diabetes & Metabolism

Atul P. Lalani, M.D.

Kimberly Rizzo, FNP-C / LeeAnna Peterson, FNP-C / Nyasha McGinnis, ANP

9500 E. Ironwood Square Drive, #201 Scottsdale, AZ 85258

Phone: 480-664-8988 Fax: 480-664-8998

Email: recordrequest@eve.phxcoxmail.com

AUTHORIZATION FOR RELEASE OF INFORMATION

Print Patient Name_____ Date of Birth_____

I authorize East Valley Endocrinology

To **RELEASE** information to:

OR

I authorize East Valley Endocrinology

to **OBTAIN** information from:

Name(Self / Provider / Facility)	**Name (Self / Provider / Facility)**
Specialty	**Specialty**
Phone	**Phone**
Fax	**Fax**

Information to be released: _____ Last progress note & lab, and any pertinent information

_____ 6 months and any pertinent information

_____ 1 year and any pertinent information

_____ Other: _____

I have read and fully understand the above authorization and hereby release the above mentioned named Health Care Facility and its employees from any legal responsibility in connection with this act. Per A.R.S. 12-2292 and A.R.S. 1401(22)(rr), three weeks is a reasonable amount of time, unless there are extenuating circumstances (to comply with this request). It is our office policy to comply with medical record requests within 5-7 working days. This consent will last while I am being treated by East Valley Endocrinology unless I withdraw consent in writing.

There is a $25.00 reproduction fee for all paper records/CD unless forwarded to another physician.

Patient or Authorized Legal Representative (state relationship) Date