

# Diabetes and Endocrine Center of Florida Inc.

## PATIENT REGISTRATION

Date: \_\_\_\_\_ Home Phone Number: \_\_\_\_\_

Please print Patient's Full Name: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

P.O. Box Street Address City State Zip

Out of State Address: \_\_\_\_\_

P.O. Box Street Address City State Zip

Date of Birth: \_\_\_\_\_

Age: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

SEX:  Male  Female

STATUS:  Single  Married  Widowed  Divorced  Separated

Nearest Relative NOT Living with You: \_\_\_\_\_

Phone Number: \_\_\_\_\_

NOTIFY IN CASE OF EMERGENCY: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Primary Insurance: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Subscriber Date of Birth: \_\_\_\_\_ Subscriber SSN: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Secondary/Supplemental Insurance: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Subscriber Date of Birth: \_\_\_\_\_ Subscriber SSN: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Patient's Employment: \_\_\_\_\_ Business Phone: \_\_\_\_\_

If minor, parent/guardian employment

If married, Spouse's Name: \_\_\_\_\_

Spouse's Employment: \_\_\_\_\_ Business Phone: \_\_\_\_\_

PERSON RESPONSIBLE

FOR BILL NAME: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_

P.O. Box Street Address City State Zip

Referred By: \_\_\_\_\_

Primary Physician: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Patient's Email Address: \_\_\_\_\_

# Diabetes and Endocrine Center of Florida Inc.

## Medical History

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Occupation: \_\_\_\_\_

STATUS:  Single  Married  Widowed  Divorced  Separated

Exercise Habits:  Sedentary  Moderately Active  Very Active

Alcohol:	<input type="checkbox"/> Yes	Frequency:	<input type="checkbox"/> Never	<input type="checkbox"/> Rare	<input type="checkbox"/> Weekly	<input type="checkbox"/> Daily
	<input type="checkbox"/> No	<input type="checkbox"/> Currently	<input type="checkbox"/> Previous	When did you stop?		
	How much (in time shown above)?					
Smoker:	<input type="checkbox"/> Yes	<input type="checkbox"/> Currently	<input type="checkbox"/> Cigarettes	<input type="checkbox"/> Cigars	<input type="checkbox"/> Pipe	<input type="checkbox"/> Chew
	<input type="checkbox"/> No	<input type="checkbox"/> Previous	If yes #packs/day:		#years:	
	When did you stop?					
Illicit Drugs	<input type="checkbox"/> Yes	<input type="checkbox"/> Currently	Drug of Choice?			
	<input type="checkbox"/> No	<input type="checkbox"/> Previous	When did you stop?			
	Are you in a Rehab Program?					

Any current concerns that need to be addressed?

Do you need medication refills? If so, please list.

### Review of Symptoms

Please check each item in the box indicated "Yes" or "No" as they relate to your recent health.

CONSTITUTIONAL	Yes	No	GASTROINTESTINAL	Yes	No
Chills			Abdominal Pain		
Fatigue			Black/Tarry Stool		
Fever			Change in Appetite		
Night Sweats			Change in Bowel Habits		
Weight loss			Constipation		
<b>EYES</b>	<b>Yes</b>	<b>No</b>	Diarrhea		
Difficulty Seeing			Difficulty Swallowing		
Double Vision			Heartburn		
Eye Pain			Incontinence of Stool		
Glasses/Contacts			Jaundice		
<b>EARS/NOSE/THROAT</b>	<b>Yes</b>	<b>No</b>	Persistent Nausea/Vomiting		
Difficulty Hearing			Rectal Bleeding		
Dizziness			Severe Indigestion		
Frequent Nose Bleeds					
<b>EARS/NOSE/THROAT</b>	<b>Yes</b>	<b>No</b>			
Frequent Sore Throat			<b>GENITOURINARY</b>	<b>Yes</b>	<b>No</b>

Reviewed By: \_\_\_\_\_ Date: \_\_\_\_\_

## Diabetes and Endocrine Center of Florida Inc.

Hoarseness			Abnormal Urine Discharge		
Nasal Stuffiness			Blood in Urine		
Ringing in Ears			Burning on Urination		
Sinus Trouble			Difficulty Urinating		
Tooth or Gum Problems			Excessive Urination at Night		
<b>CARDIOVASCULAR</b>	<b>Yes</b>	<b>No</b>	Frequent Urination		
Chest Pain			Frequent Urine Infections		
Difficulty Lying Flat			Pain on Urination		
Fainting Spells			Sugar or Protein in Urine		
Irregular Heartbeat			Urine Incontinence		
Leg Pain when Walking			(FEMALES ONLY)		
Murmur			Irregular Periods		
Palpitations			Age onset of Periods		
Shortness of Breath			Age of Menopause		
Swollen Ankles			Last Period Ended		
<b>RESPIRATORY</b>	<b>Yes</b>	<b>No</b>	<b>NEUROLOGIC</b>	<b>Yes</b>	<b>No</b>
Cough			Difficulty Speaking		
Coughing Blood			Memory Loss		
Wheezing			Numbness		
<b>HEMATOLOGICAL/LYMPHATIC</b>	<b>Yes</b>	<b>No</b>	Severe or Frequent Headaches		
Easy Bruising			Tremors		
Enlarged Lymph Glands			Severe Weakness/Paralysis		
Bleed Easily			<b>ENDOCRINE</b>	<b>Yes</b>	<b>No</b>
Prolonged Bleeding			Change in Nails		
<b>MUSCULOSKELETAL</b>	<b>Yes</b>	<b>No</b>	Decreased Sex Drive		
Back Pain			Excessive Thirst		
Joint Pain			Heat/Cold Intolerance		
Joint Swelling			Loss of Hair		
Muscle Pain			<b>ALLERGIE/IMMUNOLOGIC</b>	<b>Yes</b>	<b>No</b>
Stiffness			Hay Fever Symptoms		
<b>SKIN</b>	<b>Yes</b>	<b>No</b>	Hives		
Change in Hair or Skin			<b>PSYCHIATRIC</b>	<b>Yes</b>	<b>No</b>
Itching or Burning of Skin			Anxiety/Depression		
Other Skin Lesions			Attempted Suicide		
Rashes or Sores			Hallucinations		
			Insomnia		
			Mood Swings		
			Other Symptoms		

Reviewed By: \_\_\_\_\_ Date: \_\_\_\_\_

# Diabetes and Endocrine Center of Florida Inc.

## LIFETIME AUTHORIZATION INSURANCE ASSIGNMENTS AND AUTHORIZATION TO RELEASE INFORMATION

- I. RELEASE OF INFORMATION – I, the below named patient, do hereby authorize any physician examining and/or treating me to release to any third payer (such as an insurance company or government agency. Example: Blue Shield of Florida or Medicare) any medical, psychiatric condition, alcohol, and/or drug related condition and records concerning diagnosis and treatment when requested by such third party for its use in connection with determining a claim for such treatment and/or diagnosis.
- II. PHYSICIAN INSURANCE ASSIGNMENT – I, the below named subscriber, do hereby authorize payment to any physician examining and/or treating me of any group and/or individual surgical and/or medical benefits herein specified and otherwise payable to me for their services.
- III. MEDICARE/MEDICAID – Patient's certification authorization to release information and payment request. I certify that the information given by me in applying for payment under Title XVIII/XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to Social Security Administration Division of Family Services, or its intermediaries or carriers any information needed for this of a related Medicare/Medicaid Claim. I hereby certify that all Insurance pertaining to treatment shall be assigned to the physician treating me.
- IV. GUARANTEE OF PAYMENT – I, the below named patient/guarantor, do hereby guarantee payment of all charges incurred for the account of the patient named below. I further agree to waive demand and notice of non-payment and protest and in case suit shall be brought for the collection hereof or the same is collected upon demand of any attorney, I agree to pay all cost of collection, including reasonable attorney fees.
- V. I PERMIT A COPY OF THESE AUTHORIZATIONS AND ASSIGNMENTS TO BE USED IN PLACE OF THE ORIGINAL, WHICH IS ON FILE. This assignment will remain in effect until revoked by me in writing.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. I understand that it is my responsibility to pay any deductible amount, coinsurance, or any other balance not paid for by my insurance or third payer within a reasonable period of time not to exceed 60 days.

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Signature of Patient or Authorized Patient Representative

Physician Signature

---

Witness Signature

Date

**Diabetes and Endocrine Center of Florida Inc.**

7300 Sandlake Commons Blvd.

Complex A, Ste. # 112

Orlando, FL 32819

**AUTHORIZATION TO RELEASE INFORMATION**

In an attempt to preserve the confidential nature of the doctor-patient relationship, it is required that you complete the information listed below regarding appointments and other administrative matters.

1. Please list the family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis:

\_\_\_\_\_

2. Please list the family members or significant others, if any, whom we may inform about your medical condition **only in an emergency**:

\_\_\_\_\_

3. Please print the address of where you would like your billing statements and/or correspondence from our office to be sent:

\_\_\_\_\_

4. Please indicate if you want all correspondence from our office sent in a sealed envelope marked "Confidential".  Yes  No

5. Please print the telephone number, if any, where you want to receive calls about your appointments, labs, and x-ray results, or other health care information:

\_\_\_\_\_

6. Can confidential messages (i.e. appointment reminders) be left on your answering machine or voicemail.  Yes  No

7. If you do not have voicemail, can confidential messages be left at your place of employment?  Yes  No

\_\_\_\_\_  
Signature of Patient or Authorized Patient Representative

\_\_\_\_\_  
Physician Signature

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date

**Diabetes and Endocrine Center of Florida Inc.**

**24 HOUR CANCELLATION POLICY**

I \_\_\_\_\_ agree to pay \$50.00 for any appointment that has been cancelled, less than 24 hours, prior to scheduled time.

I understand that no exceptions will be made, and the policy is strictly enforced.

\_\_\_\_\_  
Signature of Patient or Authorized Patient Representative

\_\_\_\_\_  
Physician Signature

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date