



# Patient Information Form

Last Name: \_\_\_\_\_ First Name \_\_\_\_\_ Middle \_\_\_\_\_

Date of Birth: \_\_\_/\_\_\_/\_\_\_ SSN: \_\_\_/\_\_\_/\_\_\_ Gender: Male/Female Marital Status: Single Married Widowed Divorced  
MM DD YYYY

Home Phone:(\_\_\_\_) \_\_\_\_ - \_\_\_\_ Work Phone:(\_\_\_\_) \_\_\_\_ - \_\_\_\_ Cell Phone:(\_\_\_\_) \_\_\_\_ - \_\_\_\_

E-mail Address: \_\_\_\_\_

Home Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_ Zip Code: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Address: \_\_\_\_\_ Zip Code: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

Home Phone:(\_\_\_\_) \_\_\_\_ - \_\_\_\_ Work Phone:(\_\_\_\_) \_\_\_\_ - \_\_\_\_ Cell Phone:(\_\_\_\_) \_\_\_\_ - \_\_\_\_

Pharmacy Name: \_\_\_\_\_ Location: \_\_\_\_\_ Phone Number:(\_\_\_\_) \_\_\_\_ - \_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone Number:(\_\_\_\_) \_\_\_\_ - \_\_\_\_

Referring Physician: \_\_\_\_\_ Phone Number:(\_\_\_\_) \_\_\_\_ - \_\_\_\_

Employer Name: \_\_\_\_\_ Employment Status: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_ Zip Code: \_\_\_\_\_

**Insurance Information:**

Primary Insurance

Policy Holder: \_\_\_\_\_ Relationship: \_\_\_\_\_ D.O.B. \_\_\_/\_\_\_/\_\_\_

SSN: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

I.D./Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Secondary Insurance

Policy Holder: \_\_\_\_\_ Relationship: \_\_\_\_\_ D.O.B: \_\_\_/\_\_\_/\_\_\_

SSN: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

I.D/Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_



## Financial Policy

Please review before signing below:

**Medical Consent Authorization:** The undersigned hereby authorizes North Georgia Diabetes & Endocrinology and all employees/agents thereof to administer such treatment and/or perform such procedures as the physician deems necessary for your treatment. This consent is only for services rendered via NGDE and authorizes the assigned physician to administer such treatment as is necessary and to provide such consultations as may be necessary.

**Release of Information:** I authorize NGDE to disclose all or part of my medical records to any insurance carrier or person employed by such carrier of the purpose of collecting insurance benefits so long as I am listed on this account as having coverage with such carrier. This authorization includes release of information to employees for group insurance coverage, workers compensation carriers, and welfare agencies, if applicable to my claim for treatment. I hereby indemnify and release NGDE from any and all responsibility relative to such information.

**Assignment of Benefits:** I assign direct payment to NGDE of all medical benefits applicable to my treatment and diagnostic procedures at NGDE and grant NGDE Power of Attorney in the collection of benefits. This assignment is applicable to all future charges and fees from and including this day forward unless otherwise revoked in writing by me. I understand that I am totally responsible for payment of all fees for services rendered irrespective of insurance coverage or other responsible parties.

**Surety Agreement:** In accordance with above terms, and in consideration of the facility agreement to render information and furnish supplies, the undersigned patient and/or undersigned surety do hereby agree upon demand to pay NGDE and this facility, its agents or assigns whatever sums of money that shall become due on the amount of the patient and that such liability be joined.

**Patient's Certification Authorization:** I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or representatives, any information needed for this or a related Medicare claims. I authorize and direct that payment of benefits be made on behalf of NGDE.

## Acknowledgement of Patient Payment Responsibilities

### Verification and Payment Amount

As a courtesy, we verify your insurance benefits prior to your appointment. We encourage you to contact your insurance company directly for verification.

### Cancellations

Our office has a 24-hour voicemail. If you need to cancel, please call our office and leave a message or send an electronic message through our patient portal indicating your name, appointment time, and reason for cancellation. **If you do not notify us to cancel there will be a \$25 fee for "No Show" appointment added to your account.**

\_\_\_\_\_  
 Undersigned (Signature of Patient or Gaurdian)

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Relationship to patient

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

\_\_\_\_\_  
 Date



## Receipt of Notice of Privacy Policy

### Written Acknowledgement Form

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

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

I, \_\_\_\_\_, have had the opportunity to review a copy of North Georgia Diabetes and Endocrinology's Notice of Privacy Policies.

\_\_\_\_\_  
Signature of Patient/Gaurdian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to patient

A copy of the privacy policy can provided upon request or can be printed from our website at [NorthGeorgiaEndocrine.com](http://NorthGeorgiaEndocrine.com).

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I hereby grant permission to North Georgia Diabetes and Endocrinology to contact me and/or leave a message at either my home or workplace. These numbers are on file and can be used to confirm and appointment, to notify me of test results, to notify me that a form or prescription is ready to be picked-up, or to conduct any other relevant business that is deemed necessary.

*Personal or detailed information will not be left on an answering machine or voicemail*

\_\_\_\_\_  
Signature of Patient/Gaurdian

\_\_\_\_\_



**ENDOCRINOLOGY PATIENT INTAKE FORM**

Please complete the following questions so your doctor will have a record of your past and present medical history.

**Patient Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_ **Today's Date:** \_\_\_\_\_

**Reason for Current Visit:** \_\_\_\_\_

**Referring Physician:** \_\_\_\_\_ **Phone:** \_\_\_\_\_ **Fax:** \_\_\_\_\_

**PAST MEDICAL HISTORY: Please circle all that apply**

- |                                    |                         |                        |
|------------------------------------|-------------------------|------------------------|
| Depression                         | Blood Transfusion       | Rheumatoid arthritis   |
| Diabetes Type I                    | CHF                     | Seasonal Allergies     |
| Diabetes Type II                   | COPD                    | Seizure Disorder       |
| Hyperlipidemia (High Cholesterol)  | Coronary Artery Disease | Stroke                 |
| Hypertension (High Blood Pressure) | Crohn's Disease         | TIA                    |
| Hyperthyroidism                    | Cushing's Disease       | Vascular Heart Disease |
| Hypothyroidism                     | GERD                    | Cancer – Breast        |
| Hypercalcemia                      | HIV                     | Cancer – cervical      |
| Pituitary tumors                   | Kidney Stone            | Cancer – Colon         |
| Thyroid Disorder                   | Cirrhosis               | Cancer-Prostate        |
| Acromegaly                         | Hepatitis A             | Osteoarthritis         |
| Anemia                             | Hepatitis B             | Other:                 |
| Anxiety                            | Hepatitis C             | _____                  |
| Asthma                             | Osteopenia              | _____                  |
| Autoimmune Disorder                | Osteoporosis            | _____                  |



**PAST SURGICAL HISTORY: Please circle all that apply and date of surgery**

Bypass Surgery _____	Anesthesia Problems	YES	NO
Pacemaker/Defibrillator _____	Surgical Complications	YES	NO
Stent/Angioplasty _____	Post Op Delirium	YES	NO
Thyroidectomy _____	Other: _____		

**FAMILY HISTORY: Please circle all that apply**

I am adopted	Yes				
Diabetes	Mother	Father	Both Parents	Brother	Sister
Thyroid Disease	Mother	Father	Both Parents	Brother	Sister
Thyroid Nodules	Mother	Father	Both Parents	Brother	Sister
Hyperthyroidism	Mother	Father	Both Parents	Brother	Sister
Hypothyroidism	Mother	Father	Both Parents	Brother	Sister
Alcoholism	Mother	Father	Both Parents	Brother	Sister
Anemia	Mother	Father	Both Parents	Brother	Sister
Arthritis	Mother	Father	Both Parents	Brother	Sister
Anxiety	Mother	Father	Both Parents	Brother	Sister
Asthma	Mother	Father	Both Parents	Brother	Sister
Blood Clots	Mother	Father	Both Parents	Brother	Sister
Depression	Mother	Father	Both Parents	Brother	Sister
Growth Develop/Disorder	Mother	Father	Both Parents	Brother	Sister
Headaches	Mother	Father	Both Parents	Brother	Sister
Heart disease	Mother	Father	Both Parents	Brother	Sister
Hypertension	Mother	Father	Both Parents	Brother	Sister
High Cholesterol	Mother	Father	Both Parents	Brother	Sister
Osteoporosis	Mother	Father	Both Parents	Brother	Sister
Seizures	Mother	Father	Both Parents	Brother	Sister
Cancer: _____	Mother	Father	Both Parents	Brother	Sister



Glucose Monitored:      YES      NO      If yes, last reading; \_\_\_\_\_

Dietary Changes:      Low Fat      Low Salt      Counting Carbs      Weight Reduction Diet      Other: \_\_\_\_\_

Do you exercise regularly? YES      NO      How many times per week? \_\_\_\_\_

Types of exercise: \_\_\_\_\_

**SOCIAL HISTORY:** please circle all that apply:

Single      Married      Widowed      Divorced      Separated

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

**RISK FACTORS:**

Do you use tobacco? YES      QUIT: \_\_\_\_\_ (year)      NEVER

If currently smoking cigarettes, how many packs per day? \_\_\_\_\_

If currently smoking cigars, How many per week? \_\_\_\_\_

Do you drink alcohol? YES      NO      How many drinks per day? \_\_\_\_\_

Do you drink Caffeine? YES      NO      How many caffeinated beverages per day? \_\_\_\_\_

**MEDICATIONS:** List all medications you are currently taking:

MEDICATION	DOSE	HOW OFTEN
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**ALLERGIES:** List medication allergies and reactions (Hives, Swelling. ETC)

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## Review of Systems

### General

- |             |                           |                          |
|-------------|---------------------------|--------------------------|
| Weight loss | <input type="radio"/> Yes | <input type="radio"/> No |
| Weight gain | <input type="radio"/> Yes | <input type="radio"/> No |
| Fatigue     | <input type="radio"/> Yes | <input type="radio"/> No |

### Eye

- |                |                           |                          |
|----------------|---------------------------|--------------------------|
| Loss of vision | <input type="radio"/> Yes | <input type="radio"/> No |
| Double vision  | <input type="radio"/> Yes | <input type="radio"/> No |
| Bulging eyes   | <input type="radio"/> Yes | <input type="radio"/> No |
| Dry eyes       | <input type="radio"/> Yes | <input type="radio"/> No |

### ENT

- |                       |                           |                          |
|-----------------------|---------------------------|--------------------------|
| Persistent hoarseness | <input type="radio"/> Yes | <input type="radio"/> No |
| Sinus Congestion      | <input type="radio"/> Yes | <input type="radio"/> No |

### Cardiac

- |                        |                           |                          |
|------------------------|---------------------------|--------------------------|
| Chest pain or pressure | <input type="radio"/> Yes | <input type="radio"/> No |
| Palpitations           | <input type="radio"/> Yes | <input type="radio"/> No |
| Leg swelling           | <input type="radio"/> Yes | <input type="radio"/> No |

### Lungs

- |                     |                           |                          |
|---------------------|---------------------------|--------------------------|
| Shortness of breath | <input type="radio"/> Yes | <input type="radio"/> No |
| Cough               | <input type="radio"/> Yes | <input type="radio"/> No |
| Wheezing            | <input type="radio"/> Yes | <input type="radio"/> No |

### Dermatology

- |                       |                           |                          |
|-----------------------|---------------------------|--------------------------|
| Excessive dry skin    | <input type="radio"/> Yes | <input type="radio"/> No |
| Excessive hair growth | <input type="radio"/> Yes | <input type="radio"/> No |



Acne  Yes  No

Vitilig  Yes  No

Skin ulcer  Yes  No

### **Neurologic**

Tremor  Yes  No

Frequent headache  Yes  No

Tingling  Yes  No

Numbness  Yes  No

Burning pain in feet  Yes  No

Seizures  Yes  No

### **Psychiatric**

Depression  Yes  No

Sleep disturbances  Yes  No

Eating disorder  Yes  No

Anxiety  Yes  No

### **Endocrinology**

Excessive thirst  Yes  No

Sensitive to cold temperature  Yes  No

Sensitive to hot temperature  Yes  No

Urination at night  Yes  No

Breast growth (men)  Yes  No

Breast discharge  Yes  No



## Gastrointestinal

- Constipation  Yes  No
- Diarrhea  Yes  No
- Vomiting  Yes  No
- Nausea  Yes  No
- Heartburn  Yes  No
- Abdominal pain  Yes  No

## Urinary

- Difficulty urinating  Yes  No
- Nocturia  Yes  No
- Poor libido  Yes  No

## Gynecological

- Number of pregnancies  0  1  2  3  4  5  6  7  8
- Number of miscarriages  0  1  2  3  4  5  6  7  8
- Number of live births  0  1  2  3  4  5  6  7  8
- How many greater than 9lbs?  0  1  2  3  4  5  6  7  8
- Irregular Periods  Yes  No
- Hot flashes  Yes  No

## Musculoskeletal

- Joint stiffness  Yes  No
- Joint pain  Yes  No
- Back pain  Yes  No
- Muscle cramping  Yes  No
- Fracture  Yes  No