

**PATIENT INFORMATION**

Thank you for choosing our office! To properly serve you, we need the following information. (Please Print) All information is confidential.

Today's date:			Registration #:			
Patient's last name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid
Is patient a minor? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, parent name?		Birth date: / /		Age: /	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Street address:			Social Security no.:		Home phone no.: ( )	
Student: <input type="checkbox"/> Yes <input type="checkbox"/> No College/School:		City:		State:	ZIP Code:	
Occupation:		Employer:		Employer phone no.: ( )		
Referring Doctor						
Family Doctor						
Other family members seen here:						
Where do you prefer to receive calls? <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell _____ Best time to reach you _____						

**INSURANCE INFORMATION**

(Please give your insurance card to the receptionist.)

Person responsible for bill:		Birth date: / /	Address (if different):		Home phone no.: ( )	
Is this person a patient here? <input type="checkbox"/> Yes <input type="checkbox"/> No						
Occupation:	Employer:	Employer address:			Employer phone no.: ( )	
Is this patient covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No						
Please indicate primary insurance		<input type="checkbox"/> Care Choices	<input type="checkbox"/> BC/BS	<input type="checkbox"/> HAP	<input type="checkbox"/> Medicare <input type="checkbox"/> Other:	
Subscriber's name:		Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: \$
Patient's relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other	
Name of secondary insurance (if applicable):		Subscriber's name:		Group no.:	Policy no.:	
Patient's relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other	

**IN CASE OF EMERGENCY**

Name of local friend or relative (not living at same address):		Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )
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The above information is true to the best of my knowledge. I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the doctor.

\_\_\_\_\_  
 Patient/Guardian signature

\_\_\_\_\_  
 Date

### ADDITIONAL INFORMATION

(Please Print) All information is confidential.

Today's date:				Registration #:			
Patient's last name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.		
Is patient a minor? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, parent name?			Birth date: / /		Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F

Name of Referring Physician \_\_\_\_\_  
 Name of Primary Care Physician \_\_\_\_\_  
 Why are you seeing the doctor today? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Please list all medications you take:

Name of Medication	Dosage	# Times Per Day

List any other medications you have taken during the past 6 months but are no longer taking:

Name of Medication	Dosage	Date Stopped	Why Stopped

Past Medical History:

Do you have a personal history of:

- |   |   |   |                                       |
|---|---|---|---------------------------------------|
| <input type="checkbox"/> Diabetes                   | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Osteoporosis   | <input type="checkbox"/> Hypertension |
| <input type="checkbox"/> Thyroid Disease            | <input type="checkbox"/> Cancer           | <input type="checkbox"/> Heart Disease  | <input type="checkbox"/> Stroke       |
| <input type="checkbox"/> Hormone or gland condition | <input type="checkbox"/> Asthma           | <input type="checkbox"/> Kidney Failure |                                       |
| <input type="checkbox"/> Other _____                |   |   |                                       |

Please list any surgeries or operations that you have had and approximate dates:

\_\_\_\_\_  
 \_\_\_\_\_

Family History:

Do any close relatives have a history of (and who\_\_\_):

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Diabetes _____                    | <input type="checkbox"/> High Cholesterol _____ | <input type="checkbox"/> Osteoporosis _____  |
| <input type="checkbox"/> Hypertension _____                | <input type="checkbox"/> Thyroid Disease _____  | <input type="checkbox"/> Heart Disease _____ |
| <input type="checkbox"/> Stroke _____                      |   |  |
| <input type="checkbox"/> High calcium or parathyroid _____ |   |  |

Do you smoke?  Yes  No. If yes, how many packs/day? \_\_\_\_\_ For how long? \_\_\_\_\_

If you do not smoke, did you smoke in the past?  Yes  No. For how long? \_\_\_\_\_ When did you quit? \_\_\_\_\_

Number of alcoholic beverages consumed in a typical week (includes beer, wine, liquor)? \_\_\_\_\_

What is your occupation? \_\_\_\_\_ Marital Status \_\_\_\_\_

Weight \_\_\_\_\_ Menstrual Cycle:  Regular  Irregular. Pregnant:  Yes  No.

## ADDITIONAL INFORMATION – REVIEW OF SYSTEMS

(Please Print) All information is confidential.

Today's date:	Registration #:
Patient's last name:	First: Middle:

Do you now, or have you recently had, any problems related to the following systems? Circle Yes or No please.

### Constitutional Symptoms

Fever	Yes	No
Chills	Yes	No
Night Sweats	Yes	No
Change in Appetite, wt, energy	Yes	No
Explain _____		

### Eyes

Blurred Vision	Yes	No
Double Vision	Yes	No
Pain	Yes	No
Explain _____		

### Allergic / Immunologic

Hay Fever	Yes	No
Drug Allergies	Yes	No
Explain _____		

### Neurological

Tremors	Yes	No
Dizzy Spells	Yes	No
Numbness / tingling	Yes	No
Seizures	Yes	No
Explain _____		

### Endocrine

Excessive thirst	Yes	No
Too hot / cold	Yes	No
Tired / sluggish	Yes	No
Explain _____		

### Gastrointestinal

Abdominal Pain	Yes	No
Nausea / vomiting	Yes	No
Indigestion / heartburn	Yes	No
Change stool size/shape/color	Yes	No
Pain with swallowing	Yes	No
Explain _____		

### Cardiovascular

Chest Pain	Yes	No
Rapid Heart Rate	Yes	No
High Blood Pressure	Yes	No
Explain _____		

### Integumentary

Skin Rash	Yes	No
Boils	Yes	No
Persistent Itch	Yes	No
Explain _____		

### Musculoskeletal

Neck Pain	Yes	No
Joint Swelling/pain	Yes	No
Back Pain	Yes	No
Bone Pain	Yes	No
Explain _____		

### Ear/Nose/Throat/Mouth

Ear Infection	Yes	No
Sore Throat	Yes	No
Sinus Problem	Yes	No
Bleeding from ears, nose, gums	Yes	No
Explain _____		

### Genitourinary

Urine retention	Yes	No
Painful urination	Yes	No
Urinary frequency	Yes	No
Change in urine stream	Yes	No
Explain _____		

### Respiratory

Wheezing	Yes	No
Frequent Cough	Yes	No
Shortness of Breath	Yes	No
Explain _____		

### Hematologic / Lymphatic

Swollen glands	Yes	No
Blood clotting problem	Yes	No
Prior blood transfusions	Yes	No
Explain _____		

### Psychologic

Are you generally satisfied with your life?	Yes	No
Do you feel severely depressed	Yes	No
Have you considered suicide	Yes	No
Explain _____		

Signature of Physician: \_\_\_\_\_ Date: \_\_\_\_\_

ANN ARBOR

**Endocrinology  
& Diabetes**  
ASSOCIATES, PC

5333 McAuley Drive  
Reichert Health Building  
Room 6014  
Ypsilanti, Michigan 48197  
734.434.4430  
www.annarborendo.com

**PATIENT AUTHORIZATION  
FOR USE/DISCLOSURE OF HEALTH CARE INFORMATION**

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

Previous Name (or previous name upon which health care was provided) \_\_\_\_\_

I request and authorize Ann Arbor Endocrinology & Diabetes Associates, P.C. to release health care information of the patient named above to:

Name or organization: \_\_\_\_\_

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

City, State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

This request and authorization applies to:

\_\_\_\_\_ Health care information relating to the following treatment, condition, or dates of treatment:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_ All health care information (excludes billing)

\_\_\_\_\_ Other: \_\_\_\_\_  
\_\_\_\_\_

This information will be disclosed to facilitate patient's personal health care or be used as part of review of patient's health (i.e. employers, workers' compensation, social security agencies, disability claims, life or health insurance claims, or in cases of medical-legal matters/disputes). You are not required to identify specific reasons for disclosing/releasing health care information unless you feel it will facilitate your health care.

Please use this line to include any additional information you would like us to know in disclosing or releasing your medical information. \_\_\_\_\_

\_\_\_\_\_.

\_\_\_\_\_  
Signature of patient or patient's authorized representative      Date Signed

Relationship or status if signed by anyone other than patient (parent, legal guardian, personal representative, etc.)\_\_\_\_\_

THIS AUTHORIZATION EXPIRES ON:\_\_\_\_\_;

**OR 90 DAYS AFTER THE DATE IT IS SIGNED;**

**OR WHEN THE FOLLOWING EVENT OCCURS:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I may revoke this authorization to the extent allowed by law. If I do, I understand that Ann Arbor Endocrinology and Diabetes Associates, P.C. may have already released information about me after I gave permission. I know that revoking this authorization would not prohibit any release of information by Ann Arbor Endocrinology and Diabetes Associates, P.C. in reliance on my original authorization. I may revoke this authorization in writing to the extent allowed by law. Once Ann Arbor Endocrinology and Diabetes Associates, P.C. gives out the information that I want released, I know that Ann Arbor Endocrinology and Diabetes Associates, P.C. has no control over the information. The individual or organization that I authorized to receive the information might re-disclose it. Federal or state privacy laws may no longer protect the information.

Ann Arbor Endocrinology and Diabetes Associates, P.C. will accommodate all reasonable requests within 15 business days.

The estimated cost to you to have this information sent is \_\_\_\_\_.

ANN ARBOR

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Ypsilanti, Michigan 48197  
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**ACKNOWLEDGEMENT  
RECEIPT OF NOTICE OF PRIVACY PRACTICES  
Ann Arbor Endocrinology and Diabetes Associates, P.C.**

By signing below, I acknowledge that I have received the *Notice of Privacy Practices*  
From Ann Arbor Endocrinology and Diabetes Associates, P.C.

WITNESSES:

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

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

\_\_\_\_\_  
Date

Any specific requests/requirements: \_\_\_\_\_  
\_\_\_\_\_

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**Documentation of Failure to Obtain Signed Acknowledgement**

On \_\_\_\_\_, \_\_\_\_\_ presented this Acknowledgment of  
(day/mo/yr) (name of employee)  
Receipt of Notice of Privacy Form to \_\_\_\_\_. The patient refused  
to provide a signature when requested.