ANN ARBOR
Endocrinology & Diabetes
ASSOCIATES, PC

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

Ann Arbor Endocrinology and Diabetes Associates (AAEDA) has made the following pages available for quick download for the convenience of our patients.

Please complete the following steps before your first office visit.

1. Save this document to your computer.
2. Fill in the fields.
3. Save the document to your computer. (Complete this step before you close the document or all information will be lost.)
4. **Email the completed document to: annarborendo@gmail.com**
   You may use the Submit Form Button on the last page of this document if you are using a desktop email application such as Microsoft Outlook.
   If you are using an Internet mail service such as Yahoo please save the form and email it manually to annarborendo@gmail.com.
5. Download and read our HIPPA Privacy Statement. After reviewing the HIPPA Statement please print page 19 only. Sign page 19 and bring it with you to your first visit.

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PATIENT INFORMATION

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

Today's date:	Registration #:		☐ Mr. ☐ Miss. ☐ Mrs. ☐ Ms.
Patient's last name:	First:	Middle:	Marital status (check one) ☐ Single
			☐ Mar ☐ Div ☐ Sep ☐ Wid

Is patient a minor?	If yes, parent name?	Birth date:	Age:	Sex:
☐ Yes ☐ No				☐ M ☐ F

Street address:			Home phone no:
City:	State:	Zip Code:	Cell phone no:
Occupation:	Employer:		Employer phone no:

Referring Doctor:	
Family Doctor:	
Other family members seen here:	
Where do you prefer to receive calls? ☐ Home ☐ Work ☐ Cell	Best time to reach you:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Subscriber's name:	Birth date:	Address (if different):	Home phone no:

Is this person a patient here? ☐ Yes ☐ No

Please indicate primary insurance ☐ Priority Health ☐ BC/BS ☐ HAP ☐ Medicare ☐ Other

Group no:	Policy no:	Co-payment:
		$

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Birth date:	Group no.:	Policy no.:

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ 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.:

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:			❑ Mr. ❑ Mrs. ❑ Ms. ❑ Miss.			
Is patient a minor?	If yes, parent name?				Birth date:		Age:		Sex:	
❑ Yes ❑ No									❑ M ❑ F	

Name of Referring Physician____

Name of Primary Care Physician____

Why are you seeing the doctor today?____________________________________

____

____

On the next page, please list all medications you take.

Also on the next page, please list any other medications you have taken during the past 6 months but are no longer taking.

Past Medical History:

Do you have a personal history of:

❑ Diabetes ❑ High Cholesterol ❑ Osteoporosis ❑ Hypertension

❑ Thyroid Disease ❑ Cancer ❑ Heart Disease ❑ Stroke

❑ Hormone or gland condition ❑ Asthma ❑ Kidney Failure

❑ 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___):

❑ Diabetes_______________ ❑ High Cholesterol_____________ ❑ Osteoporosis_____________

❑ Hypertension___________ ❑ Thyroid Disease_____________ ❑ Heart Disease_____________

❑ Stroke_________________ ❑ 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_______________

Height __________Weight __________ Menstrual Cycle: ❑ Regular ❑ Irregular. Pregnant: ❑ Yes ❑ No.

ADDITIONAL INFORMATION – MEDICATIONS

(Please Print) All information is confidential.

Please list all medications you take:

Name of Medication	Dosage	# Times Per Day

Please 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

Additional information for your physician:

ADDITIONAL INFORMATION – REVIEW OF SYSTEMS

<table>
<tr><td colspan="3">All information is confidential.</td></tr>
<tr><td colspan="2">Today's date:</td><td>Registration #:</td></tr>
<tr><td>Patient's last name:</td><td>First:</td><td>Middle:</td></tr>
</table>

Do you now, or have you recently had, any problems related to the following systems? Check 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:* ____________________

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Dear Patient:

For your convenience and safety, we are introducing a computerized prescription program that will improve both the accuracy and convenience of prescribing medications. This program will allow for the electronic transmission of your prescriptions directly to your pharmacy of choice, and will eliminate your waiting time. In most cases, it will also accommodate the transmission of your prescription to mail order pharmacies.

To implement this new program, we need to collect some information from you on your pharmacies of choice. We will define one pharmacy as your primary; however, you may also provide the information for a second pharmacy, which may be utilized as an alternative. In addition, if you have a mail order benefit program, please provide that information by selecting the appropriate box below.

We understand that you may not have the complete pharmacy information with you today. However, if you could please provide us with as much information as possible regarding the location such as pharmacy name, street name, and city, we will most likely be able to search for your preferred pharmacy electronically.

Patient Name: ____ ***D.O.B.*** _______________

Please list your drug allergies, indicating reaction type, or check "***no know drug allergies***" below:

☐ No known drug allergies

List: ____

____

Primary Pharmacy:
Name: (CVS, Meijer, etc.) ____

Street Name and City: ____

Phone: _______________________________________ Fax: ______________________________

Alternative Pharmacy:
Name: (CVS, Meijer, etc.) ____

Street Name and City: ____

Phone: _______________________________________ Fax: ______________________________

Mail Order:

☐ Not Applicable ☐ Medco ☐ Express Scripts, Inc

☐ Care Mark ☐ PharmaCare ☐ Walgreens

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INSURANCE/REFERRAL AND "NO SHOW" POLICY
(OUR FINANCIAL POLICY)

We are dedicated to providing the best possible care for you, and we want you to completely understand our financial policies.

1. Payment is due at the time of service unless arrangements have been made in advance by your carrier.

2. Health plans or insurance companies may require a referral to be seen by our doctors. You must have a current referral to be seen in the practice or you may not be seen. You and your physician, not our office, is responsible for obtaining the referral prior to your visit. If you do not have a referral and circumstances involving your care require immediate attention, then you will be asked to sign a form that obligates you for payment until such referral is obtained. If you cannot obtain that referral then you will be responsible for full payment.

3. Keep in mind that your insurance policy is basically a contract between you and your insurance company. As a service to you, we will file your insurance claim if you assign the benefits to the doctor – in other words, if you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment. If we later receive a check from your insurer, we will refund any overpayment to you.

4. We have made prior arrangements with many insurance companies and other health plans to accept an assignment of benefits. We will bill them, and you are required to pay a co-payment at the time of your visit.

5. Not all insurance plans cover all services. In the event your insurance plan determines a service to be "not covered", you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.

6. We will bill your insurance company for all services provided in the hospital. You are responsible for any balance due.

7. Failure to honor financial obligations or "no shows" for visits may lead to termination from the practice/physician's office. You will be notified in writing of such termination. Our physicians will continue to serve you for 30 days (unless otherwise specified) allowing you and your referring physician to make alternative arrangements for your care.

8. Our office manager(s) is available to answer any specific insurance or financial questions.

____

Signature of patient (or responsible party, if minor) Date

____

Please print the name of the patient

Jas/kr
11/05

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**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 maters/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 _______________.