MIDTOWN
ENDOCRINE ASSOCIATES

REGISTRATION FORM

Patients Legal Name: _____ Sex: *M* / F DOB: _____ Age: _____

Race: _____ Ethnicity: _____ Primary Language: _____

Phone Number: Home# _____ Cell#_____Work#_____

Primary Address:_____

City/ State / Zip code

Email Address: _____

Patient's Social Security# _____ Responsible Party: _____ Relationship:_____

Name and phone# of referring physician: _____

Name and phone# of primary physician: _____

Patient's employer/ school: _____ Occupation:_____

Emergency Contact information: _____ Phone# : _____

Address: _____ Relationship: _____

Can we contact this person regarding : Appointments: YES / NO Test Results: YES / NO Prescriptions: YES /NO

Primaryreason for visit _____

ALLERGIES TO MEDICATIONS:_____

Insurance Information

Primary Insurance Name: _____

Mail Claims to: _____

Insured Name: _____

Relationship: _____

Policy/Group#: _____

Insured's Birth Date: _____

Insured's Employer: _____

Secondary Insurance Name: _____

Mail Claims to: _____

Insured Name: _____

Relationship: _____

Policy/Group#: _____

Insured Birth Date: _____

Insured's Employer: _____

- **AUTHORIZATION TO CALL** above listed numbers or if unavailable, leave message on answering machine or adult family members.
- **RELEASE OF INFORMATION** I hereby authorize Midtown Endocrine Associates to release any information required in the course of their examination or treatment for Medicare or insurance purposes.
- **AUTHORIZATION TO PAY:** I acknowledge full responsibility for all charges regardless of possible insurance coverage. I hereby authorize Midtown Endocrine Associates to obtain on my behalf, any insurance covered by **THE PRIVACY ACT** from my insurance company file(s). I hereby authorize payment directly to the physician for medical/surgical benefits. I am responsible for any charges/fees associated with collections of my account in the event that I default

Signed:_____ **Date:**_____

MIDTOWN
ENDOCRINE ASSOCIATES

Joan F. Bailey, M.D

2200 N. 3rd Street
Phoenix, AZ 85004
Phone: 602-258-9955 Fax: 602-258-9933

AUTHORIZATION FOR USE OR DISCLOSURE OF INFORMATION

Patient Name: _____

In connection with the medical services that I am receiving from the medical professionals at Midtown Endocrine Associates, I hereby authorize the above-named medical professionals and/or Midtown Endocrine Associates to disclose any/or all information concerning my medical condition and treatment, including copies of applicable hospital and medical records, to:

A. Any third party payer covering the medical services of the patient;
B. Other health care professionals and institutions involved in the delivery of health care to the patient;
C. The proponent of any legally sufficient subpoena, or in response to a court order;
D. Employees and agents of the practice, to the degree necessary to facilitate the provision of health care services and payment for such services;
E. Pharmacies; and
F. Other parties as otherwise required by law.

In each case, Midtown Endocrine Associates shall take reasonable steps to ensure that only the minimum necessary information is disclosed in accordance with the above. I further understand that I have been given access to Midtown Endocrine Associates privacy notice and that I have had the opportunity to place special restrictions upon the consent hereby given:

Special Restrictions:

_____

_____

_____

This consent is valid from the date executed until revoked in writing by the patient.

_____ ____/____/____
Patient Signature Date

_____ ____/____/____
Witness Signature Date

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NO SHOW / LATE ARRIVAL POLICY AND AGREEMENT

No Show Policy:

Midtown Endocrine Associates is committed to providing exceptional care. Unfortunately, when a patient cancels without giving enough notice, they prevent another patient from being seen.

A “No Show” is a patient who fails to appear for a scheduled appointment without providing a 48 hour cancellation notice. Further, a rescheduled appointment that is less than the 48 hour cancellation notice is still considered a cancellation and is treated as such. There is a $100.00 charge for new patient and $50.00 charge for an established patient No Show or Late Cancellation.

Late Arrival Policy:

Our providers, medical assistants and staff aim to make your visit a pleasurable one. In our efforts to make your visit more comfortable and to minimize your wait time, our office has implemented a late arrival policy.

Patients are asked to arrive to their appointments before their scheduled appointment time. New patients are to arrive and check-in 20minutes before their scheduled appointment time. Established patients are to arrive and check-in 10 minutes before their scheduled appointment time. This allows enough time for the registration and check-in process to be completed before the actual appointment time.

If a patient arrives more than 5 minutes later than their scheduled appointment time, the appointment may need to be rescheduled. This is to ensure that the patients who arrive on time do not wait longer than necessary to see the provider. You may be given the option to wait for another appointment time on the same day if one is available. This process will ensure patients that do arrive on time are seen in a timely manner.

The providers and staff appreciate your compliance and understanding with these policies so that we can continue to provide excellent medical care as well as excellent customer service.

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NO SHOW / LATE ARRIVAL POLICY AND AGREEMENT

As a patient or guardian for a patient receiving services from Midtown Endocrine Associates, I understand that I am responsible to cancel or reschedule appointments and arrive for scheduled appointments within appropriate timeframes. I do hereby agree to the following:

1. I will cancel a scheduled appointment at least 48 hours before the appointment.
2. I agree to pay a $100.00 for new patient and $50.00 established patient appointment fee when I fail to cancel my appointment without 48 hour notice before the appointment.
3. Allowances will be made for failing to keep my appointment due to unavoidable or reasonably unforeseen circumstances.
4. The medical professionals at Midtown Endocrine Associates may terminate my services if I do not cancel or fail to attend two scheduled appointments in a year.
5. Should Midtown Endocrine Associates terminate my services, they will send me a “termination of services letter. This letter will explain that a 30-day grace period will be given to enable me to secure alternative services, and will also allow prescription refills when medically appropriate for 30 days from the date of the “termination of services” letter.

_____

Patient / Guardian Signature Date

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NEW PATIENT QUESTIONAIRRE

Please complete this prior to your appointment and fax in advance to 602-258-9933.
*** Please also bring the completed form to your appointment**

GENERAL INFORMATION:

Name:_____ Language(s) Spoken:_____

Address:_____

Daytime Phone #: _____ Cell Phone #: _____

Date of Birth: _____/_____/_____ Age:_____ Email Address: _____

Can we contact you at this address for medical issues? ❑ Yes ❑ No

Ethnicity: ❑ Hispanic ❑ Non Hispanic

Race: ❑ Caucasian ❑ Black ❑ Asian ❑ Indian

❑ Native American ❑ Other _____

REFERRING DOCTOR:

NAME	ADDRESS	PHONE NUMBER/FAX NUMBER
		/

❑ Adrenal Issues ❑ Diabetes Type 1 ❑ Diabetes Type 2

❑ Diabetes in Pregnancy ❑ Hyperthyroidism ❑ Hypothyroidism

❑ Osteoporosis ❑ PCOS ❑ Prediabetes

❑ Thyroid Cancer ❑ Pituitary ❑ Other _____

ALLERGIES: ❑ No Known Allergies

MEDICINE	REACTION

SURGICAL HISTORY Please list surgeries you have had, date and hospital ❑ **None**

Surgery	Date	Location

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NEW PATIENT QUESTIONAIRRE

MEDICATIONS/SUPPLEMENTS

Name of Medication/Supplement	Dosage	Date Started
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

MEDICAL HISTORY Check if you have or have ever had these conditions

CARDIAC
- ❑ High Blood Pressure
- ❑ Heart Attack
- ❑ Heart Murmur
- ❑ Irregular Heart Beat
- ❑ Mitral Valve Prolapse
- ❑ Peripheral Vascular Disease
- ❑ Stroke

RESPIRATORY
- ❑ Asthma
- ❑ Chronic Cough
- ❑ Bronchitis
- ❑ Emphysema

MUSCULOSKELETAL
- ❑ Arthritis
- ❑ Other _____

GASTROINTESTINAL
- ❑ Ulcers
- ❑ Irritable Bowel
- ❑ Constipation
- ❑ Diverticulitis
- ❑ Crohns/Colitis

GENITOURINARY/REPRODUCTIVE
- ❑ Many Urine Infections
- ❑ Kidney Stones
- ❑ Infertility

Males:
- ❑ Erectile Dysfunction

Females:
- ❑ Gestational Diabetes
- ❑ Irregular Periods
- ❑ Date of Last Period:_____
- ❑ PAP _____
- ❑ Mammogram_____

HEMATOLOGIC
- ❑ Easy Bleeding/Bruising
- ❑ Hx of Blood Clot

NEUROLOGIC
- ❑ Spine/Back Injury
- ❑ Seizures
- ❑ Migraines
- ❑ Recurrent Headaches

CANCER
- ❑ Type _____

ENDOCRINE
- ❑ Diabetes
- ❑ Thyroid
- ❑ Osteoporosis
- ❑ High Cholesterol
- ❑ Steroid Use
- ❑ Excessive Weight Gain
- ❑ Pituitary

Females:
- ❑ Polycystic Ovary Syndrome
- ❑ Unwanted Facial or Body Hair

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NEW PATIENT QUESTIONAIRRE

FAMILY HISTORY – are you adopted? ❑ Yes ❑ No

Have any of your family members ever had any of the following? (Please cross out any family listed below that does not apply to you, ie – if you do not have a brother, cross out Brother.

	Mother	Father	Sister	Brother	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Negative Hx	Other
Arthritis-Rheum										
Arthritis*Osteoporosis										
Asthma										
Cancer										
Diabetes										
Heart Failure										
High Cholesterol										
Hypertension										
Migraines										
Rashes/Skin*Problems										
Seizures										
Stroke										
Thyroid Disease										

REVIEW OF SYSTEMS – please check if you are <u>currently</u> experiencing any of the following

GENERAL WELL-BEING:	**BREAST:**	❑ **EARS, NOSE, THROAT, MOUTH:**
❑ Weight Loss	❑ Pain	❑ Ulcers
❑ Weight Gain	❑ Nipple Discharge	❑ Sinus problems
❑ Fever	❑ Breast Lump	❑ Hearing Problems
❑ Fatigue	❑ Rash	❑ Ringing in the Ears
❑ Excessive Thirst		❑ Difficulty Swallowing
❑ Excessive Hunger	**CARDIOVASCULAR:**	
❑ Problems Sleeping	❑ Shortness of Breath	**EYES:**
❑ Heat Intolerance	❑ Chest Pain	❑ Vision Changes
❑ Cold Intolerance	❑ Palpitations	❑ Contacts/Glasses
	❑ Swelling	❑ Excessive Tearing / Eye Discharge
BLOOD SYSTEM:	**RESPIRATORY:**	**MUSCULOSKELETAL:**
❑ Bleed Easily	❑ Coughing	❑ Weakness
❑ Bruise Easily	❑ Coughing up Blood	❑ Muscle Pain
❑ Enlarged Lymph Nodes	❑ Wheezing	
❑	❑	
❑	❑	
❑	❑	
❑	❑	
❑	❑	

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NEW PATIENT QUESTIONAIRRE

REVIEW OF SYSTEMS (Continued)		
GASTROINTESTINAL:	**NEUROLOGICAL:**	**URINARY/GYNECOLOGIC:**
❑ Diarrhea	❑ Dizziness	❑ Blood in Urine
❑ Constipation	❑ Headache	❑ Painful Urination
❑ Nausea/Vomiting	❑ Near Passing Out	❑ Urgency or Frequency
❑ Bloody Stools	❑ Numbness	
❑ Pain with bowel movement	❑ Difficulty walking	Women: ❑ Irregular Periods
❑ Abdominal Pain	❑ Memory Problems	❑ Vaginal Discharge
PSYCHOLOGICAL:	**SKIN:**	**SLEEP DISTURBANCE:**
❑ Depression	❑ Acne	❑ Difficulty Falling Asleep
❑ Severe Mood Swings	❑ Hair Loss	❑ Waking up Frequently at night
❑ Anxiety	❑ Excessive Hair Growth	❑ Excessive Daytime Sleepiness
❑ Confusion	❑ Dryness	
❑ Severe Agitation	❑ Rash	

SOCIAL HISTORY						
Are you currently married or with a partner?	❑ Yes	❑ No				
Do you smoke?	❑ Yes	❑ No	❑ Quit			
If yes: How many cigarettes a day? _____			For how long? _____			
If quit: When did you quit? _____						
When you did smoke, how many cigarettes a day? _____			For how long? _____			
Do you Exercise?	❑ Yes	❑ No				
If yes: Aerobic activity?	❑ Yes	❑ No	Times per week?: _____			
Strength training?	❑ Yes	❑ No	Times per week?: _____			
Yoga/Stretching?	❑ Yes	❑ No	Times per week?: _____			
Do you drink alcohol?	❑ No	❑ Yes, _____ drinks per		❑ Day	❑ Week	❑ Month
Do you consume Caffeine?	❑ No	❑ Yes, _____ drinks per		❑ Day	❑ Week	❑ Month
Do you currently use recreational drugs?			❑ Yes	❑ No		
Have you used recreational drugs in the past?			❑ Yes	❑ No		
Are you currently employed?			❑ Yes	❑ No		
If yes: Type of work:_____						

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NEW PATIENT QUESTIONAIRRE

IS THERE ANYTHING SPECIFIC YOU WISH TO DISCUSS WITH YOUR PHYSICIAN THIS VISIT?

IF YOU HAVE DIABETES complete the following questions:

At what age was diabetes diagnosed? _____

Have you seen a diabetes educator? ❑ Yes ❑ No

Have you seen a nutritionist in regards to diabetes? ❑ Yes ❑ No

What type of diabetes do you have? ❑ Type 1 ❑ Type 2 ❑ Diabetes in Pregnancy ❑ Unknown

Do you check your blood sugars at home? ❑ Yes ❑ No

If yes, What is a high reading for you? _____

- What is a low reading for you? _____
- Do your sugars ever go below 70? ❑ Yes ❑ No

  If yes, is this ❑ Daily ❑ Weekly ❑ Monthly ❑ Rarely
- Are you aware of when your sugar is low? ❑ Yes ❑ No
- Have you been hospitalized for low blood sugars? ❑ Yes ❑ No

  If yes, when _____ and where _____

Do you know what an A1c is? ❑ Yes ❑ No

Do you know your A1c? ❑ Yes ❑ No If yes what is it? _____

Have you ever been hospitalized for high blood sugars? ❑ Yes ❑ No

If yes, when_____ and where _____

Do you have diabetes related eye problems? ❑ Yes ❑ No Eye Doctor: _____

When was your last eye exam? _____ ❑ Never

Do you have foot problems? ❑ Yes ❑ No Foot Doctor: _____

When did you last give a urine sample for your diabetes? _____ ❑ Never

Do you have diabetes related kidney problems? ❑ Yes ❑ No

When did you last have a cardiac assessment? _____ ❑ Never

Do you have heart disease? ❑ Yes ❑ No

Males: Do you have erectile dysfunction? ❑ Yes ❑ No

Do you have any specific issues you would like to address with your physician regarding your diabetes?

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NEW PATIENT QUESTIONAIRRE

IF YOU ARE BEING SEEN FOR THYROID CANCER, complete the following questions:		
At what age was your thyroid cancer diagnosed? Age: _____		
Did you have surgery for your thyroid cancer? ❑ Yes ❑ No		
If yes, list surgery location: _____		
Did you have radioactive iodine? ❑ Yes ❑ No		
If yes, do you recall the dose? Dose: _____		
Do you have a history of low calcium? ❑ Yes ❑ No		
If yes, what medication are you taking for it? Medication: _____		
When was your last neck ultrasound performed?		
Date: _____ Location: _____ ❑ Not applicable		
When was your last whole body scan performed?		
Date: _____ Location: _____ ❑ Not applicable		
Do you know your most recent TSH and Thyroglobulin level? ❑ Yes ❑ No		
TSH: _____ Thyroglobulin level: _____ Date: _____		
IF YOU ARE BEING SEEN FOR OSTEOPOROSIS, complete the following questions:		
Please Check Yes or No if any of the following apply to you:		
	Yes	No
Have you ever been treated for osteoporosis? If yes, with what medications? _____ From what dates: _____ to _____		
Is there a family history of osteoporosis and/or hip fracture? If yes, list family member _____		
Do you have a history of hip or spine fracture? If yes, list location _____ age _____		
Do you have a history of any other bone fractures? If yes, list location _____ age _____		
Are you lactose-intolerant?		
Do you have celiac disease/gluten intolerance?		
Have you ever been diagnosed with a thyroid disorder?		
Have you ever been diagnosed with a calcium disorder?		
Do you have a history of kidney stones?		
Do you have a history of anorexia?		
When was your last bone density test? ❑ N/A Date: _____ Location: _____		
Do you take Calcium or Vitamin D? ❑ Yes ❑ No		
If yes, Calcium dose: _____ Vitamin D dose: _____		
For Females,		
Date of last period _____		
Are you in menopause? ❑ Yes ❑ No		
If yes, were you treated with Hormone replacement therapy? ❑ Yes ❑ No		
Indicate from what dates – from _____ to _____		

PATIENT SIGNATURE					DATE
PROVIDER SIGNATURE					DATE