PARTNERS IN ENDOCRINOLOGY /DR. JYOTHI MAMIDI JUAREZ

REGISTRATION FORM

(Please Print)

Today's date (mm/dd/yyyy):	Primary care physician (PCP):

PATIENT INFORMATION

Patient's Last Name:	First:	Middle:	☐ Mr. ☐ Ms. ☐ Mrs. ☐ Dr.	Marital status (check one) ☐ Single ☐ Divorced ☐ Widow ☐ Married ☐ Separated

Is this your legal name? ☐ Yes ☐ No	If not, what is your legal name?	(Former name):	DOB:mm/dd/yyyy	Age:	Sex: ☐ M ☐ F

Street address:	SSN (XXX-XX-XXXX):	Home Phone:	Cell Phone:

P.O. box:	City:	State (XX):	ZIP Code:

Occupation:	Employer:	Employer Phone:

REFERRED BY:

REASON FOR CLINIC VISIT:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	DOB:	Address (if different):	Home Phone (if different):

Is this person a patient here? ☐ Yes ☐ No

Occupation:	Employer:	Employer address:	Employer Phone:

Is this patient covered by insurance? ☐ Yes ☐ No

Please indicate **primary insurance**

Subscriber's name:	Subscriber's SSN:	DOB:	Group no.:	Policy no.:	Co-payment:

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

Name of **secondary insurance** (if applicable):	Subscriber's name:	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:	Work Phone:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Partners in endocrinology /Dr. Jyothi Mamidi Juarez or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

Partners in Endocrinology, Dr. Jyothi Mamidi Juarez

Social

Marital Status	Single ☐	Married ☐	Divorced ☐	Separated ☐
Occupation	Retired	Active		Type
Do You? (Check yes or no and explain if yes)				
Get Exercise	No ☐	Yes ☐	Hrs/week	Exercise type
Use illegal drugs	No ☐	Yes ☐		Type
Consume alcohol	No ☐	Yes ☐	Ounces per week	
Use tobacco currently	No ☐	Yes ☐	Packs per day	
Use tobacco in past	No ☐	Yes ☐	Packs per day	

Past Medical

What medications are you currently taking (include supplements and vitamins)? Please list dose and frequency.

1.	7.
2.	8.
3.	9.
4.	10.
5.	11.
6	12

Do you have any allergies/reactions? {please list reactions}

1.
2.

Previous Surgeries/Date:

1.	Date:
2.	Date:
3.	Date:
4.	Date:

Problems for which you have seen a physician or have been treated for:

Diabetes	No ☐	Yes ☐	Year	Type	
Thyroid Disease	No ☐	Yes ☐	Year	Type	
Nodule/Tumor/Cancer	No ☐	Yes ☐	Year	Type	
High Cholesterol	No ☐	Yes ☐	Year		
Stroke	No ☐	Yes ☐	Year	Type	
High Blood Pressure	No ☐	Yes ☐	Year		
Heart Problem	No ☐	Yes ☐	Year	Type	
Eye Disease	No ☐	Yes ☐	Year	Type	
Kidney Disease	No ☐	Yes ☐	Year	Type	

Family

Do any of your blood relatives have or have had any of these diseases or…
Do any other problems run in the family:

Diabetes	No ☐	Yes ☐	Type
Nodule/Tumor/Cancer	No ☐	Yes ☐	Type
Heart Problem	No ☐	Yes ☐	Type
Thyroid Disease	No ☐	Yes ☐	Type
High Blood Pressure	No ☐	Yes ☐	
Stroke	No ☐	Yes ☐	
High Cholesterol	No ☐	Yes ☐	
Other Family History			

Diabetes

Answer the following questions if you area a DIABETIC:

1. What type of meter/test strips do you use?			
2. Insulin pump?	No ☐	Yes ☐	Type
3. Last eye exam	Date:		
4. Last flu vaccine	Date:		

Partners in Endocrinology, Dr. Jyothi Mamidi Juarez
Review of Systems

Place a check in any box, if you have had any of the following symptoms:

Constitutional Symptoms				Skin			
Weight Gain	☐	Fatigue	☐	Dry Skin	☐	Rash	☐
Weight Loss	☐	Malaise	☐	Hives	☐	Skin Lesions	☐
						Itching	☐
Ear-Nose-Throat				**Eyes**			
Sinus Pressure	☐	Neck Pain	☐	Visual Changes	☐	Eye Pain	☐
Sore Throat	☐	Neck Fullness	☐				
Respiratory				**Cardiovascular**			
Cough	☐	Wheezing	☐	Chest Pain	☐	Leg pain with walking	☐
Shortness of Breath	☐			Palpitations	☐	Swollen Ankles	☐
Gastrointestinal				**Endocrine**			
Trouble Swallowing	☐	Nausea	☐	Cold Intolerance	☐	Excessive Sweating	☐
Abdominal Pain	☐	Diarrhea	☐	Heat Intolerance	☐	Excessive Hair Growth	☐
Change in Stools	☐	Loss of appetite	☐	Brittle Hair	☐	Excessive Thirst	☐
Constipation	☐			Brittle Nails	☐	Excessive Hunger	☐
Genitourinary/Urinary				**Neurology**			
Painful Urination	☐	Hot Flashes	☐	Dizziness	☐	Headaches	☐
Excessive Urination	☐	Currently Pregnant	☐	Numbness	☐	Tremors	☐
Irregular Periods	☐	Poor Erection	☐	Weakness	☐		
		Poor Sex Drive	☐				
Musculoskeletal				**Allergies/Immune**			
Back Pain	☐	Joint Pains	☐	Seasonal Allergies	☐		
Muscle Weakness	☐			Food Allergies	☐		
Psychology				**Hematology/Lymphatic**			
Anxious	☐	Depressed	☐	Easing Bruising	☐	Swollen Glands	☐
Stressed	☐						

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