Arizona Diabetes & Endocrinology, PLC PERSONAL HEALTH HISTORY INFORMATION

All questions contained in this questionnaire are strictly confidential and will become part of your medical record

Name (First, MI, Last):	Date:	Date of Birth:	
Reason for referral to our practice:			
MEDICAL HISTORY			
□ High Blood Pressure	□ High Cholesterol	□ Thyroid Disorder	□ Diabetes
Surgeries:			
Hospitalizations/Major Injuries:			
MEDICATIONS			
List your medications, including: prescribed drugs, birth control, pain medication, sleep aids, over-the-counter vitamins and supplements. (Include name, strength, frequency taken)			
List Allergies or Adverse Reactions to medications or other substances below: (Include name of substance & reaction)			
SOCIAL HISTORY			
Do you use: (Place an X in the box next to those you use) □ Cigarettes □ Pipe □ Cigars □ Chewing tobacco □ Beer □ Wine □ Hard liquor □ Recreational drugs			
FAMILY HISTORY			
□ Diabetes Mellitus □ Osteoporosis □ Pituitary Disease □ Thyroid Disease □ Heart Disease □ Hypertension □ Cancer □ Infertility problems □Obesity □ High blood calcium/Kidney stones □ Adrenal gland disease			
VACCINATIONS			
□ Influenza □ Pneumonia □ Tetanus			

SEXUAL/MENSTRUAL HISTORY		
Are you sexually active?	Are you using birth control?	Which type?
When was your last period?	Was it regular or irregular?	Are you trying to become pregnant?

PLACE AN "X" IN ANY BOX NEXT TO A PROBLEM OR DISTURBANCE YOU HAVE HAD IN THE PAST YEAR			
CONSTITUTION	□ Recent weight changes	□ Changes in appetite	□ Persistent fever
	□ Night sweat-hot flashes	□ Tire easily sensitivity	
	□ Weakness or paralysis	□ Hot/Cold Sensitivity	
SKIN/HAIR/NAILS	□ Skin rash	□ Dry skin	□ Change in hair or nails
	□ Excessive perspiration	□ Skin itching	□ Wounds
EYES	□ Eye pain	□ Eye redness	□ Blurred /double vision
	□ Glasses or contacts	□ Eye Infections	
EARS	□ Ringing in the ears	□ Discharge from ears	□ Ear pain
	□ Decrease in hearing		
NOSE	□ Frequent nose bleeds	□ Stuffiness /discharge	□ Loss/lack of smell
MOUTH	□ Sore tongue or gums	□ Bleeding gums	□ Persistent hoarseness
NECK	□ Neck swelling	□ Neck stiffness	□ Sore throat
CHEST	□ Frequent cough	□ Wheezing	□ Shortness of breath
	□ Bloody sputum	□ Painful breathing	□ Chest pain/discomfort
HEART	□ Swelling of hands/feet	□ Palpitations	□ Leg cramp on walking
	□ Heartburn	□ Enlarged veins	
STOMACH/BOWELS	□ Abdominal cramping	□ Nausea/Vomiting	□ Chronic diarrhea
	□ Chronic constipation	□ Rectal bleeding	□ Black tarry stools
URINARY TRACT	□ Frequent urination	□ Increase in thirst	□ Painful urination
	□ Leakage of urine	□ Blood in urine	
GENITAL	□ Lack of sex drive	□ Painful sex	
NEURO	□ Numbness/tingling	□ Tremor	□ Headaches
	□ Memory loss	□ Sleep changes	□ Depressed mood

MUSCULOSKELETAL	□ Backaches □ Joint pain or stiffness □ Swollen joints □ Muscle cramps/spasms
MEN ONLY	□ Difficulty with erection □ Testicle lump/pain □ Penis discharge
WOMEN ONLY	□ Period absent □ Days between period □ Heavy flow □ Menstrual pain/cramps □ Bloody discharge □ Other discharge □ Breast lump/discharge □ Breast pain Date of Last Mammogram: _____ # Pregnancies: _____ # Of births: _____

Is there anything else you would like your doctor to know?

_____

_____

_____

Arizona Diabetes & Endocrinology, PLC (AZDE) Patient Registration

Last Name_____First Name_____Middle Initial_____

Date of Birth_____SSN_____

Address_____Apt/Unit_____

City_____State_____Zip_____Driver's License No_____ State Issued_____

Gender: Male Female (circle one)

Primary Phone_____ Cell / Home / Work (circle one) Is this your preferred phone Y / N

Secondary Phone_____ Cell / Home / Work (circle one) Is this your preferred phone Y / N

Email address_____(by providing your email you consent to use our patient portal)

Relationship Status: S M W D Other Do you need an interpreter? Y / N

(Emergency Contact Information)

Name_____Relationship_____Phone_____

Guarantor (if not patient) Last Name _____First Name_____ Middle Initial_____

Birthdate_____ SSN_____

Address_____ Apt/Unit_____

City_____State_____ Zip_____

(Primary Insurance)

Insurance Name_____ID#_____Group#_____

Policy Holder **(if not patient) Name**_____DOB_____SSN_____

(Secondary Insurance)

Insurance Name_____ID#_____Group#_____

Policy Holder **(if not patient) Name**_____DOB_____SSN_____

I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original. I hereby authorize Arizona Diabetes & Endocrinology, PLC to apply for benefits on my behalf and I request that payment from my insurance company be made directly to Arizona Diabetes & Endocrinology, PLC for medical benefits otherwise payable to me. **I understand that I am financially responsible for charges not covered by my insurance.** I hereby certify that the information I have reported with regard to my insurance coverage is correct.

Patient Signature_____ Date_____

Arizona Diabetes & Endocrinology, PLC (AZDE) Coordination of Care

AZDNE providers **do not act as primary care providers**. Services are limited to endocrine conditions and direct complications. We strongly recommend you have a primary care provider who can manage your general health.

Patient Last Name_____First Name_____DOB_____

Did you bring any medical records with you today? Y / N *** If yes, please give to the receptionist ***

Did you bring your medication list with you today? Y / N *** If yes, please give to the receptionist ***

(Physicians involved in the patient's care)

Primary Care Physician_____Phone_____Fax_____

Referring Physician_____Phone_____Fax_____
(if different from Primary Care)

Ophthalmologist (Eye)_____Podiatrist (Foot)_____

Cardiologist (Heart)_____Nephrologist (Kidney)_____

Neurologist (Brain and Nervous System)_____

(Pharmacy Information)

Local_____Phone_____Cross Streets_____

Mail Order_____Phone_____

Compounding Pharmacy_____Phone_____

Our office requires 72 hours advance notice for all prescription refill requests. Please contact your pharmacy directly when you need refills. **Refills will not be given to patients who do not attend regularly scheduled appointments.**

(Diabetic Patients Only)

Did you bring any of the following with you today? (please circle)

Blood Sugar Meter / Log Book / Insulin pump *** If yes, please give to the receptionist ***

Please bring your meter, log book, insulin pump and medication list to **all future appointments.** Thank you.

Arizona Diabetes & Endocrinology, PLC (AZDE) HIPAA and Release of PHI

Last Name _____First Name_____Middle Initial_____ DOB:_____

□ I Do □ I Do NOT give my permission for AZDNE to leave messages regarding my lab results, treatment, diagnosis, appointments, billing/payments, and any other pertinent information regarding my care at the following number(s):

Mobile Number_____Home Number_____

Do you consent to receive automated **email** messages from our office? Yes / No

Do you consent to receive automated **phone** messages from our office? Yes / No

Do you consent to receive automated **text** messages from our office? Yes / No

By signing below, I acknowledge that I have received the Notice of Privacy Practices of AZDNE which explains its legal duties and privacy practices with respect to my Protected Health Information (PHI). I understand that I may refuse to sign this acknowledgement. I authorize AZDNE to disclose my PHI as specified below to the individuals listed below.

Name_____Relationship_____Phone_____
Information to be released (circle): ALL / Treatment / Diagnosis / Appointment / Billing / Other_____

Name_____Relationship_____Phone_____

Information to be released (circle): ALL / Treatment / Diagnosis / Appointment / Billing / Other_____

Name_____Relationship_____Phone_____

Information to be released (circle): ALL / Treatment / Diagnosis / Appointment / Billing / Other_____

The above authorizations shall remain in effect until I provide Arizona Diabetes & Endocrinology, PLC with written revocation. I understand I cannot revoke this authorization retroactively for information already released. I understand when Arizona Diabetes & Endocrinology, PLC discloses PHI pursuant to this authorization, they can no longer guarantee confidentiality or prevent re-disclosure and the information may no longer be protected by federal privacy rules. I understand by signing this authorization I agree to allow Arizona Diabetes & Endocrinology, PLC and its staff to disclose the protected health information to the above stated person(s) and/or entity.

Patient or legally authorized representative Signature_____ Date _____

Printed name if signed on behalf of the patient_____Relationship_____

FOR OFFICE USE ONLY

I, _____(Employee Name), made a good faith effort to obtain written acknowledgement of the receipt of the Notice of Privacy Practices of AZDNE for the above-named patient. I was unable to obtain written acknowledgement due to the following reason:

□ Individual refused to sign □ Communication barrier □ An emergency situation □ Other_____

Arizona Diabetes & Endocrinology, PLC (AZDE) Office and Financial Policies

OFFICE & PHONE HOURS: Our office is open Monday through Thursday from 8:00AM-5:00PM and Friday from 8:00AM-12:00PM. Our phone lines close for lunch from 12:00-1:00. Phone lines are not open past noon on Friday.

LAB HOURS: Effective 11/19/2018 we will offer in-office phlebotomy services Monday through Thursday from 7:00AM-11:30AM and 1:00PM-4:30PM as well as Friday from 7:00AM-11:30AM. We do not draw outside orders unless they are presented in conjunction with an order from one of our providers.

APPOINTMENT ARRIVAL and CONFIRMATION/CANCELLATION: We require ALL patients to arrive 20 minutes prior to their scheduled time. This allows our clinical staff to perform intake and minimize the wait time for all patients. If you arrive more than 10 minutes late your appointment will be rescheduled at the provider's discretion.

If the provider has ordered bloodwork, please have this done 1-2 weeks prior to your appointment. **If the results are not in our office 72 hours prior to your visit we will cancel your appointment.**

INSURANCE: We only bill for services rendered by Arizona Diabetes & Endocrinology. If you would like us to bill your medical insurance, you must present a current insurance card to our receptionist each time you visit our office. If we do not have a valid card on file or are unable to verify your eligibility, payment of our cash fee will be expected at the time of service. If your insurance denies payment you are financially responsible for the balance due. Questions regarding claim payment should be directed to your insurance company directly.

REFERRALS: If your insurance company requires a referral to see a specialist, the referral must be on file in our office in order for you to be seen by the provider**. It is your responsibility to ensure we have a valid referral** including a referral number (if required by insurance) as well as a valid number of visits and current date range authorized by your primary care physician. You will be asked to reschedule your appointment if we do not have a valid referral at the time of check-in.

COPAYS and CO-INSURANCE: If your insurance plan requires a copay or co-insurance it is due at the time of your visit.

OUTSTANDING ACCOUNT BALANCE: Your account balance must be paid in full prior to seeing the provider. If you are unable to pay your balance you may ask to setup a payment plan. If you default on the payment plan, your account will be sent to our collection agency and we will not be able to schedule future appointments.

COLLECTION ACCOUNTS and RETURN CHECK FEE: Accounts that are 90 days past due will be sent to an external collection agency and the patient will be discharged from our practice for non-payment. A fee of $30 will be assessed for any returned check.

PRESCRIPTION REFILLS: Prescription refill requests should be directed to your pharmacy. Requests will be processed within 48-72 hours. It is the patient's responsibility to plan ahead for refills as we do not guarantee a same-day response. **Refills will not be given to patients who do not attend regularly scheduled appointments.**

LAB ORDERS: Lab orders are sent electronically to the preferred lab in accordance with your insurance. Please contact the draw station directly in order to verify whether or not your order is on file. We do not send lab orders through the mail.

ON-CALL SERVICES: A provider will be on-call after business hours for emergencies only. Prescription refills WILL NOT be addressed by the on-call provider. Please plan ahead to ensure you are requesting refills before running out of your medication(s).

I have read the above policies and I agree to abide by them. I understand policies may change without notice and it is my responsibility to seek updated information from the practice website or material posted in the office.

Name_____Signature_____Date_____

ARIZONA DIABETES & ENDOCRINOLOGY, PLC

3489 S. Mercy Road, Suite 101, Gilbert, AZ 85297 Phone (480) 646-8433 Fax (480) 646-8434 www.azdne.com

Authorization for Release of Medical Information

Patient Name (Please Print):_____Date of Birth:_____

□ Obtain Information From **OR** □ Release Information To
Mark One Selection: Physician Facility Self Other

Name: _____Phone: _____Fax: _____

Address: _____

Information to be Released:

□ Complete Records
□ Progress Notes
□ Lab/X-Ray Reports
□ Whole Body Scan
□ Billing Information
□ Biopsy/Pathology Report
□ Surgical Report
□ Other: _____

Information to be Restricted:

The patient restricts the release of the following:
□ Behavior & Mental Health Records
□ Communicable Diseases (including HIV/AIDS
□ Alcohol & Drug Abuse Treatment
□ Genetics □ Other

Form and Method of Release:

Records should be sent by □ Hard Copy/Paper □ Soft Copy/Electronic Format

□ Mail to address above □ Fax to number above □ Notify patient to pick-up when ready
(Requests containing more than 30 pages must be picked up or mailed in electronic format)

Service Dates:

□ All Dates **OR** □ From_____ to_____

Purpose of Release:

□ Treatment/Continuity of Care
□ Transfer of Medical Care
□ Insurance Coverage
□ Disability Determination
□ Legal Purposes
□ Moving
□ Personal
□ Other: _____

This authorization will expire one (1) year from the date of signing, or as indicated here: _____and may be revoked at any time by providing written notice of revocation. I understand I cannot revoke this authorization retroactively for information already released. I understand when Arizona Diabetes & Endocrinology, PLC discloses PHI pursuant to this authorization, they can no longer guarantee confidentiality or prevent re-disclosure and the information may no longer be protected by federal privacy rules. I understand by signing this authorization I agree to allow Arizona Diabetes & Endocrinology, PLC and its staff to disclose the protected health information to the above stated person(s) and/or entity. I understand my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this form.

Signature: _____ Date Signed: _____

Printed Name of Person Signing (if not patient): _____