CREEDMOOR CENTRE ENDOCRINOLOGY
WHERE IT ALL COMES TOGETHER

New Patient Form

Demographic Data: **Today's Date:**_____

Patient Name:_____Preferred Name:_____Preferred pronoun:_____
First Last

Date of Birth:_____ Cell Phone:_____Email address:_____

Sex: ○ M ○ F ○Other Gender Assigned at Birth: ○ M ○ F

Race: ○White ○African-American ○Hispanic ○Asian ○Other_____ Language Spoken at Home:_____

Is patient under age of 18? ○No ○ Yes, Please complete box below:

Name(s) of Parent(s) or Legal Guardian (paperwork must be presented):

_____
First Last

Email address:_____Cell phone_____

Home phone:_____ Work Phone:_____Ext_____

Preferred Contact: ○ Home Ph ○Cell ○Work ph ○Email ○US Mail

Address_____Apt_____City_____Zip_____

Primary MD:_____Name of office:_____

Referring MD:_____Name of office:_____

Reason for visit: *If Diabetes, please STOP and complete New Diabetes Patient Intake Form

_____

Past Medical History:

Major events, hospitalizations, surgeries:_____

_____

Women: Pregnancies(#):____ Live births(#):____Miscarriages (#): ____Are you pregnant? ○No ○Yes, Due Date___

Men: Have you fathered children? ○No ○ Yes

Allergy/Reaction: (example: Penicillin/Rash)_____

_____

Ongoing medical problems:_____

_____

_____

_____

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Patient Name:_____
First Last

Family History:

Relation	State of Health	Age at Death	Health Problems
Father			
Mother			
Brothers			
Sisters			
Children			

Do any Blood Relatives have:

○Type I Diabetes ○Type II Diabetes ○Thyroid condition ○Cancer ○Osteoporosis ○PCOS ○Pituitary problem

○Heart Disease or Stroke ○High Cholesterol ○ Other Endocrine problems_____

Preventive care:

Exercise: ○No ○Yes→ How many minutes/day?_____How many days/week?_____ Hours of sleep/ night?_____

Contraceptive used_____Last menstrual period: _____ Last PAP smear:_____

Last mammogram:_____ Last colonoscopy:_____Are your immunizations up to date? ○Yes ○ No

Social history:

Marital Status: _____Occupation:_____Last completed or Current Grade in school:_____

Recreational Substance Use:

	Ever Used?	Current use?	Quit date?	How much?	How often?
Tobacco					
Alcohol					
Street Drugs					
Other					

Preferred Pharmacy Name_____ Street_____City_____Zip_____,

and/or phone:_____

Current Medications and Dosing (please include vitamins and supplements)

_____

_____

_____

_____

_____

CREEDMOOR CENTRE ENDOCRINOLOGY
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GENERAL
- Fever or chills
- Night Sweats
- Change in appetite
- Fatigue
- Fainting
- Poor sleep
- Unexplained weight loss
- Weight gain
- Recent trauma
- Lumps or bumps
- Unexplained falls

MUSCULOSKELETAL
- Joint pain
- Joint stiffness
- Joint swelling
- Noisy joints
- Arthritis
- Joint deformities

GENITOURINARY
- Frequent urination
- Blood in urine
- Painful urination
- Lack of bladder control
- Urinating at night
- Urinating more volume than expected

NEUROLOGICAL
- Headaches
- Seizures
- Confusion
- Difficulty with balance
- Difficulty with speech
- Numbness
- Tingling
- Dizziness

EYE
- Visual changes
- Eye pain
- Blurred vision
- Double vision
- Blind spots
- "floaters"

GASTROINTESTINAL
- Abdominal Pain
- Cramping
- Food avoidance
- Bloating
- Indigestion
- Heartburn
- Nausea
- Vomiting
- Constipation
- Diarrhea
- Vomiting blood
- Red blood in stool
- Black stools

SKIN/BREAST
- Itching
- Hives
- Rash
- Sore that won't heal
- Stretch marks
- Dark, thick skin at back of neck
- Eczema
- Change in moles
- Acne
- Dry Skin
- Breast pain
- Breast lumps
- Breast discharge

RESPIRATORY
- Cough
- Wheezing
- Coughing up blood/mucus
- Shortness of breath

CARDIOVASCULAR
- Chest pain
- Hard to exercise
- Waking up gasping for air
- Can't sleep flat
- Palpitations
- Rapid heart beat
- Pain in legs with walking
- Swollen ankles

EAR, NOSE, MOUTH, THROAT
- Runny nose
- Ringing in ears
- Toothache
- Sore throat
- Ear ache
- Hearing loss
- Sinus problems
- Nosebleeds
- Bleeding gums
- Difficulty swallowing
- Hoarseness
- Painful swallowing

ENDOCRINE
- Cold Intolerance
- Heat Intolerance
- Excess hunger
- Excess thirst
- Excessive hair growth
- Hair loss
- Unexplained tanning

ALLERGIC/ IMMUNOLOGIC
- Anaphylaxis
- Lymph node swelling
- Allergic reactions

PSYCHIATRIC
- Depression
- Anxiety
- Crying Spells
- Decreased work or school performance
- Personality change
- Mood swings

HEMATOLOGIC
- Anemia
- Bruising
- Unexpected bleeding
- History of blood transfusion
- Refused for blood donation

MEN ONLY
- Erection difficulties
- Poor sex drive
- Lump in testicles
- Penis discharge

WOMEN ONLY
- Abnormal PAP
- Painful periods
- Spotting
- Irregular periods
- Vaginal Discharge
- Hot flashes
- Painful intercourse
- Poor sex drive

Consent Forms

Consent to Treatment

I am a new patient at Creedmoor Centre Endocrinology, P.A. By signing this form, I consent to be treated by the providers of this practice.

My doctor needs more medical facts about my health. I, _____, ask for and allow Dr. Warren-Ulanch and staff to give me the needed medical treatment and services that he or she recommended.

I understand treatment and services may include:

- lab tests,
- screening tests (tests that can find an illness early, before a person shows signs of having the disease),
- diagnostic tests (tests that shows if a person has a certain illness or health problem), and
- routine exams.

I understand that no promises have been made to me about the results of any treatment or services.

_____ _____

Signature of Patient or Responsible Party Date and Time

****

Consent for treatment of a minor child:

I, being the parent or guardian of _____, ask and allow Creedmoor Centre Endocrinology, P.A. to do necessary health services for my child, even if I am not present.

Below is a list of people who are allowed to bring my child in for treatment:

_____ _____

_____ _____

_____ _____

Signature of Patient or Responsible Party Date and Time

****

Consent for use of email:

By signing this form, I hereby grant permission for Creedmoor Centre Endocrinology, P.A. to contact me via email at the address provided. Please be case sensitive. This email address will not be shared with any other entity.

Email: _____

_____ _____

Signature of Patient or Responsible Party Date and Time

Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name: _____ **Date of Birth:** _____ **Date**:_____

The undersigned hereby acknowledges that a copy of the HIPPA laws and guidelines has been provided to them by Creedmoor Centre Endocrinology.

I authorize Creedmoor Endocrinology's staff to leave medical, appointment and/or account information pertaining to my care by the following methods. This authorization expires one year from the date signed. **I will assume the responsibility to notify them of any changes in this information.**

If we are unable to reach you, are there any relatives or friends with whom you authorize our office to discuss your health information? Please list name(s), relationship(s), and their phone number(s) below:

Name	Relationship	Phone Number
Name	Relationship	Phone Number
Name	Relationship	Phone Number

List of Providers for Medical Release of Information

I, (Patient or Guardian)_____hereby authorize:

Creedmoor Centre Endocrinology
8340 Bandford Way Ste. 001
Raleigh, NC 27615
Phone: 919-845-3332 Fax: 919-845-3395

To release and forward my medical records, including machine readable medical and demographic data to the following providers:

First & Last Name Provider	Medical Specialty	Practice Name	Office Phone and Fax #
	General Practioner/ Primary Care Doctor		

FINANCIAL POLICY CREEDMOOR CENTRE ENDOCRINOLOGY

Office Hours: Our office is open Monday through Friday 8:00am-5:00pm. If you have a life threatening emergency, please dial 911.

Appointments: Patients are seen by appointment only. We realize your time is valuable and we do our best to honor your appointment time. Our practice may encounter unforeseen emergencies and delays may occur. We may at times need to make changes to your appointment date and time. We ask for your patience and understanding during these times. If you are unable to keep your appointment and need to cancel, we request that you notify us at least 24 hours in advance to avoid "No Show" charges. The charge will be $50.00 for a follow up visit or $100.00 for a consult or PE visit. There will be no exceptions unless approved by Dr. Warren-Ulanch.

Insurance: We ask for your cooperation in providing us with the following:

- Your current and correct insurance information. Please provide us with a copy of your insurance card at each office visit.
- Your co-pay is expected to be paid at the time of service
- If you have an HMO that requires a referral, we will expect that you present this at check-in.
- If your insurance does not pay in full, we do not do payment plans. You will be expected to pay your account in full once billed. We contract our billing with Kareo. Any billing issues should be directed to Kareo. Their contact phone number is 866-562-3456
- After 90 days, Kareo will send delinquent accounts to collections.

High-Deductible Plans: If you have not reached your deductible, you will be asked to pay $125 at time of service.

Credit Card on File:

With high-deductible plans, we understand more expenses are being borne by the patients. For this reason, we are using Credit Card on File. You will not have to worry about statements or mailing payments. When our office receives information from your insurance, any remaining portion will be charged to your credit card. A maximum of $175 per month will be charged. A receipt will be emailed to you. If payment is declined, we will request updated credit card information or an alternative form of payment.

Self-Pay and Non-Participating Insurances:

Self-pay is anyone who does not have health insurance or has an insurance which Creedmoor Centre of Endocrinology is not contracted with. Insurance for these patients will be filed as a courtesy. If your non-participating insurance pays less than our usual and customary charges, you will be billed for the difference. Self-pay patients who do not have health insurance, will be required to make full payment at check-out.

Returned Checks: Returned checks are subjected to a $25.00 service fee.

Medical Records: There is no charge for Medical Record transfer if faxed from physician to physician. If you would like a copy of your medical record, the charge is $50.00. Any Life Insurance Co. or Attorney will be charged $50.00 prior to release of records. There is a charge for other documents that the physician may need to complete for you. This Charge is $75.00.

Signature of Responsible Party:_____ Date:_____