Endocrinology Associates of New Jersey

General Patient Information

Last Name: _____ First Name: _____

Home Tel: _____ Work Tel: _____

Cell Tel: _____ Other Tel: _____

Sex (Circle One): Male Female E-Mail Address: _____

Address: _____

_____

Date of Birth: _____/_____/_____ Occupation: _____

S.S.# _____

Family Doctor: _____ Tel: _____

Emergency Contact: _____

Relationship to patient (Circle One): Spouse Parent/Guardian Other: _____

Tel: _____

Insurance Information

Primary Insurance: _____

Secondary Insurance: _____

Insured Name: _____

Relationship to patient (Circle One): Self Spouse Parent/Guardian

Chief Complaint: Please list (in order of importance) the present health concerns, symptoms or problems you wish to address through your consultation with an Endocrinologist.

_____

_____

_____

_____

Medical History: Please provide the following information:
List your chronic medical conditions (like Hypertension, Diabetes, etc.)

_____

_____

_____

_____

_____

List all surgeries, serious illnesses/injuries/broken bones and hospitalizations (including year)

_____

_____

_____

_____

_____

Patient's Name_____ **Date:**_____

Medications: Please list all medications you are currently taking. Include all non-prescription drugs or over-the-counter supplements (Multivitamin, Calcium, Vitamin D, etc.).

Medication	Dose	Frequency

Family History: Please specify if any blood relative has had any of the following:

Condition	No	Yes	Specify
Diabetes			
High Cholesterol			
Hypertension			
Heart Problems			
Thyroid Problems			
Osteoporosis			
Fractures			
Osteoarthritis			
GERD/Acid Reflux			
Asthma/COPD			
Cancer			
If other, please specify:			

Allergies: Please list all allergies (including foods, drugs and environment). Specify type, location and severity of reaction. If none, check: □ No Allergies.

_____

_____

_____

Habits: Do you ever use the following? If yes, how much, how often and for how many years?

Item	No	Yes	Specify
Tobacco			
Alcohol			
Illicit Drugs (specify)			
Caffeine (Coffee, Tea; specify)			
Other			

Patient's Name_____ **Date:**_____

Review of Systems: Do you have or have you had any of these in the past year?
Please mark "YES" or "NO"

yes	no	Recent weight changes	yes	no	Chest pain or tightness
yes	no	Blurred or Double Vision	yes	no	Fainting/dizziness
yes	no	Difficulty Hearing	yes	no	Irregular Heartbeat
yes	no	Urinary retention/incontinence	yes	no	Skin problems/wounds
yes	no	Chronic or Frequent cough	yes	no	Nausea or vomiting
yes	no	Shortness of Breath	yes	no	Abdominal pain or heartburn
yes	no	Snoring	yes	no	Impotence
yes	no	Fever/night sweats	yes	no	Depressed or Sad
yes	no	Bleeding or bruising easily	yes	no	Diarrhea/constipation
yes	no	Frequent or Chronic Headaches	yes	no	Nervous or Anxious
yes	no	Hair loss	yes	no	Sleep problems
yes	no	Seizures	yes	no	Painful or swollen joints
yes	no	Memory Problems	yes	no	Back or neck pain
yes	no	Difficulty swallowing	yes	no	Difficulty or pain with walking
yes	no	Rashes or Itching	yes	no	Fatigue/weakness
yes	no	Falls	yes	no	Menstrual problems/age of menopause:

Nutritional/Exercise History: If you are seeing the Endocrinologist for Diabetes or issues concerning your weight please detail your usual diet (including beverages) and exercise.

Breakfast
Snack
Lunch
Snack
Dinner
Snack
Type of exercise
Duration of exercise
Times per week

Patient's Signature:_____ Date:_____

Reviewing Physician:_____ Date:_____

Patient's Name_____ **Date:**_____

Communication: I wish to be contacted in the following manner (check all that apply):

□ **Home Telephone**

□ OK to leave message with detailed information

□ Leave message with callback number only

□ **Cell Phone**

□ OK to leave message with detailed information

□ Leave message with callback number only

□ OK to send SMS message

□ **Work Telephone**

□ OK to leave message with detailed information

□ Leave message with callback number only

□ **Written Communication**

□ OK to mail to home address

□ OK to fax to:_____

□ **Other**:_____

Designation of Others for Disclosure of Protected Health Information:
I agree that Endocrinology Associates of New Jersey may disclose certain documents and information regarding my health to a family member, close personal friend, or other caregiver because such a person is involved with my health care.

I designate the person(s) listed below as individual(s) involved with my health care provided by Endocrinology Associates of New Jersey for the purpose of making disclosures described above. I understand that I am not required to list anyone. I also understand that I may change this list at any time by submitting a written request.

Print Name	**Relationship**	**Date of Birth**

Patient's Signature:_____

Date**:**_____

Endocrinology Associates of New Jersey

HIPAA PRIVACY

Acknowledgment of Receipt of Privacy Notice

By signing this acknowledgment of Receipt of Notice of Privacy Practices (the "Notice"), I acknowledge and agree that I have received, read and understand the Notice of the Notice Privacy Practices for review and to keep for my records on the date identified below.

I understand that Endocrinology Associates of New Jersey may use and disclose necessary personal health information (for example, my name, address, subscriber identification number, exam information and/or type of products provided) to another party to permit Endocrinology Associates of New Jersey to perform its administrative duties, provide me with medical care services and products, process my vision benefit claims and communicate with me regarding medical care services provided by Endocrinology Associates of New Jersey (for example, mailings of exam reminders or information about services / products provided by Endocrinology Associates of New Jersey).

I can be assured that this location does not sell my personal health information of any kind to a third party for such party's own use. I authorize the Location to submit my medical benefit claims to my plan sponsor or health plan to receive reimbursement directly for the medical services and products that I have received from Endocrinology Associates of New Jersey.

_____ _____

Patient Signature or Patient's legal Representative Date

Effective: 08-30-18