Patient's Personal Information **Marital Status**: [ ] Single [ ] Married [ ] Divorced [ ] Widowed **Sex**: [ ]Male [ ] Female

Name: _____ _____ _____
(Last Name) (First Name) (Middle Initial)

Home Address: _____ Apt #: _____

City: _____ State : _____ Zip Code: _____

Home Phone: (_____) _____- _____ Cell Phone: (_____) _____- _____

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

Social Security#: _____ - _____ - _____

Employer Information

Occupation: _____

Employer Name: _____

Address: _____ Suite/Unit #:_____

City: _____ State: _____ Zip Code: _____

Work Phone: (_____)_____-_____

Patient's / Responsible Party Information **Relationship to Patient:** [] Self [] Spouse [] Child [] Other: _____

Name: _____ _____ _____
(Last Name) (First Name) (Middle Initial)

Date of Birth: _____/_____/_____ Social Security#: _____ - _____ - _____

Home Address: _____ Apt #: _____

City: _____ State: _____ Zip Code: _____

Home Phone: (_____)_____- _____ Work Phone: (_____)_____- _____ Cell Phone (_____)_____- _____

Patient's Insurance Information * Please present insurance cards to receptionist. *

Relationship to insured: [] Self [] Spouse [] Child [] Other: _____

PRIMARY Insurance Name: _____

Address: _____City: _____ State : _____ Zip Code: _____

Name of insured: _____ Date of Birth: _____/_____/_____

Policy #: _____ Group #: _____ Co-pay : $ _____

Relationship to insured : [] Self [] Spouse [] Child [] Other: _____

SECONDARY Insurance Name: _____

Address: _____City: _____ State : _____ Zip Code: _____

Name of insured: _____ Date of Birth: _____/_____/_____

Policy #: _____ Group #: _____ Co-pay : $ _____

Patient's Referral Information

Referred by**:** _____ Phone: (_____)_____- _____

Patient's Primary Medical Doctor

Name: _____ Phone: (_____)_____- _____

Patient's Other Medical Doctors

Name: _____ Specialty: _____

Name: _____ Specialty: _____

Name: _____ Specialty: _____

Name: _____ Specialty: _____

Pharmacy Information

Name: _____

Address: _____City: _____State : _____ Zip Code: _____

Phone: (_____)_____- _____ Fax: (_____)_____- _____

Emergency Contacts

Name: _____Relationship _____

Address: _____City: _____State : _____ Zip Code: _____

Home Phone: (_____)_____- _____ Work Phone: (_____)_____- _____ Cell Phone (_____)_____- _____

Name: _____Relationship _____

Address: _____City: _____State : _____ Zip Code: _____

Home Phone: (_____)_____- _____ Work Phone: (_____)_____- _____ Cell Phone (_____)_____- _____

☐ I agree to have my blood tested for HIV, HBV, and HCV, at no charge to me, as part of this facility's post exposure follow-up procedure as required by OSHA regulations. The results of this blood test will be used **only for evaluation purposes and will remain in confidential medical records.**

_____ _____

Patient Signature Date

_____ _____

Witness Signature Date

COMPREHENSIVE HISTORY AND PHYSICAL ENDOCRINOLOGY EVALUATION (FEMALE)

NAME_____, _____ _____DATE BORN_____/_____/_____Age_____
(Last) (First) (Initial)

On the two lines below, please describe the problem for which you are seeing the doctor:

_____

_____

History of the present illness (HPI)

_____
_____
_____
_____
_____
_____

Prescription medications, antacids, aspirin, supplements, vitamins, health products, or laxatives you are now taking**:**

Name of Medicine	Dose strength	When taken	To treat what	Year begun	Prescribed by

PAST MEDICAL HISTORY:

How healthy are you now (circle one): GOOD FAIR POOR

List drugs you are allergic to:_____ Year of last: Tetanus booster ____

Pneumococcal Vaccine ____ Flu Vaccine ____Hep B Vaccine ____ Check if you had rheumatic fever____ Malaria____

Other serious infections _____

PAST HOSPITAL ADMISSIONS & SURGERIES:

Year admitted	Cause of illness	Year admitted	Cause of illness

FAMILY HEALTH HISTORY:
(Such as heart disease, high blood pressure, stroke, cancer, diabetes, thyroid disease, mental illness)

Relationship to you	AGE IF STILL LIVING	IF NOT ALIVE, AGE PERSON DIED	DISEASES PERSON HAS OR HAD AND CAUSE OF DEATH IF DECEASED
Mother			
Father			
Brother			
Brother			
Brother			
Brother			
Sister			
Sister			
Sister			
Sister			

PERSONAL AND SOCIAL HISTORY:

Where were you born? _____With whom do you live now?_____ Children (give sex and age in years)_____ Circle one: Married Divorced Widowed Remarried Never Married

Present weight: _____pounds The most you ever weighed (not pregnant):_____pounds

Has your weight changed in the past year? Gained _____pounds Lost _____pounds

Reason for weight gain or loss: _____

Your height: _____inches If you have lost height, how much? _____inches

Average number of hours you sleep each day ____hours

If you have trouble sleeping, what is the problem? _____

How many hours of exercise or heavy work do you do each week? ____hours

Amount and type of alcohol used each week:_____

Have you used "recreational" drugs (marihuana, heroin, crack). What?_____

If you have problems with your sexual function, what is the problem? _____

If you have used tobacco, what?_____ How much?_____

For how long? _____ years If you have quit, what year did you quit? _____

Highest education level you completed (circle one) GED High school College Graduate school

If you are on a restricted diet, what do you restrict?_____ If you drink caffeine beverages (coffee, cola, tea), how many ounces a day? _____ounces

What are your hobbies, recreational activities?_____ What is your current job? _____Your past jobs_____ If you served in the military service, give branch_____and years _____-_____

Religion (Catholic, Protestant, Jewish…)_____ Religious?_____

CHECK ALL THAT APPLY

KIDNEYS & BLADDER

Had a kidney ultrasound or IVP ____

Get up at night just to urinate____ How many times a night? ___

Unable to control bladder and have accidents ____

Weaker and slower urine stream ____

Blood in urine ____

Kidney stone ____

Urinary, kidney or bladder infections ____

Venereal disease ____

Burning or pain during urination ____

Protein in urine ____

Constant feeling of a need to urinate ____

Trouble or hesitancy in getting urine flow going ____

SEXUAL HEALTH

Prostate Trouble ____

Burning or discharge from penis ____

Swelling, pain, tenderness, or a lump on testicles ____

Trouble with erections ____

Had a vasectomy ____

LUNGS and HEART

Short of breath even with little effort ____

Heart murmur ____

Wake up at night very short of breath ____

Exposed to tuberculosis____ Year _____ Treatment given? _____ Positive skin test for tuberculosis ____

Pain, discomfort, or tightness in chest ____

High blood pressure ____

Pain or lumps in breasts____

Breast biopsies ____

Persistent cough ____

Cough up blood ____

Cough up phlegm or sputum ____

Asthma ____

Palpitations or racing of the pulse ____

Repeated episodes of bronchitis ____

Drenching night sweats ____

Swelling of the legs or ankles ____

Severe pain in the calves while walking or running ____

Had an electrocardiogram (EKG) ____ Year of last one_____

Had a chest x-ray ____ Year of last one _____

Had a mammogram ____ Year of last one _____

Had an exercise or stress test ____ Year done _____

STOMACH, INTESTINES & LIVER

Severe problem with stomach gas, bloating, or passing gas ____

Heartburn ____

Use antacids regularly ____

Frequent nausea ____

Have frequent or unexplained vomiting ____

Vomit blood ____

Stomach or abdominal pain ____

Bloody bowel movements ____

Loose bowels most of the time ____

Constipation most of the time ____

Hemorrhoids ____

Rectal pain or bleeding ____

Colon polyps ____

Ulcers ____

Had hepatitis or yellow jaundice ____

Had an Xray of the stomach ____

Had an endoscopy (a lighted tube exam) of stomach ____

Had a CAT scan or MRI of the abdomen ____

Had an X-ray or ultrasound of gallbladder ____

Had a lighted tube exam of the colon (sigmoidoscopy or colonoscopy)____

Had a barium enema Xray of the colon ____

MUSCLES, JOINTS & SKELETON

Had fractures of bones____

Severe or unusual muscle cramps ____

Stiff joints____

Painful muscles ____

Swollen joints ____

Pain or stiffness in spine ____

Regular or repeated treatment for back ____ Treatment is by _____

EYES, EARS, NOSE, THROAT

Loss of hearing ____

Earache or drainage ____

Loss of balance or vertigo ____

Lightheadedness ____

Hoarseness ____

Loss of sense of smell ____

Sinus trouble ____

Constant or frequent nasal stuffiness ____

Loss of ability to taste food ____

Repeated nose bleeding ____

Chronic dryness of the mouth ____

Wear glasses or contacts ____

Blurred vision and glasses don't help____

Double vision ____

Glaucoma ____

Sense of something in the eyes all the time____

Year last saw dentist: _____ Name of dentist: Dr._____ Year last saw eye doctor: _____

Name of eye doctor: Dr. _____

NERVOUS AND PSYCHIATRIC

Nervous breakdown ____

Psychiatric treatment ____ Treated by _____

Unusual weakness of muscles ____

Sick headaches ____

Numbness of part of body ____ Which part? _____ Paralysis in or loss of use of part of body ____ Which part?_____

Stroke ____

Pass out, fainting or loss of consciousness ____

Seizures or convulsions ____

Unusual shaking or trembling ____

Depressed ____

Easily annoyed or irritable____

Disturbed greatly by family___ By work ____ By other things ____

Considering suicide____ By what means?_____

Attempted suicide ____By what means?_____

Memory failing____

ENDOCRINE

Big problem with heat or hot weather ____

Big problem with cold or cold weather ____

Excessive perspiration ____

Trouble swallowing ___

Goiter or enlarged thyroid gland ____

Nodule on thyroid gland ___

Tender thyroid or pain in the front of your neck ____

Excessive appetite ____

Poor appetite ____

Exhaustion or fatigue most of the time ____

Reduced libido or a poor sex drive____

Breast discharge ____

Change in voice ____

Excessive body or facial hair ____

Problem with acne____

OTHER PROBLEMS

Pain in feet ____

Phlebitis____

Pulmonary embolus ____

Bleeder ____

Rash now or often ____

Chronic itching ____

Growth in the skin ____

Had or now have cancer ____Type?_____

Radiation therapy ____For?_____

Anemic ____

Swollen lymph glands ____

ENDOCRINOLOGY CONSULTANTS, P.C.
ADULT & PEDIATRIC WELLNESS CENTER
www.endocrinewellness.com

Osteoporosis: Can It Happen to You?

Osteoporosis is a major public health threat for 44 million Americans. Ten million individuals already have osteoporosis and 34 million more have low bone mass placing them at increased risk for developing osteoporosis and the fractures it causes. Eighty percent of those affected by osteoporosis are women. Known as "the silent thief," osteoporosis progresses without symptoms or pain until bones start to break, generally in the hip, spine, or wrist.

QUESTIONS	YES	NO
1. Do you have a small, thin frame and/or are you Caucasian or Asian?		
2. Have you or a member of your immediate family broken a bone as an adult?		
3. Are you a postmenopausal woman?		
4. Have you had an early or surgically-induced menopause?		
5. Have you taken high doses of thyroid medication or used glucocorticoids ≥5mg a day (for example, prednisone) for 3 or more months?		
6. Have you taken, or are you taking, immunosuppressive medication or chemotherapy to treat cancer?		
7. Is your diet low in dairy products and other sources of calcium?		
8. Are you physically inactive?		
9. Do you smoke cigarettes or drink alcohol in excess?		

The more times you answer "yes," the greater your risk for developing osteoporosis.

Osteoporosis is a complex disease and not all of its causes are known. However, when certain risk factors are present, your likelihood of developing osteoporosis is increased. Therefore, it is important for you to determine your risk of developing osteoporosis and take action to prevent it now.

Osteoporosis is preventable if bone loss is detected early. If the questions suggest that you are at risk for developing osteoporosis, see your healthcare provider. Your healthcare provider may recommend that you have a bone mass measurement test. This test will safely and accurately measure your bone density and reliably predict your risk of future fracture.

If you already have osteoporosis, you can live actively and comfortably by seeking proper medical care and making some adjustments to your lifestyle, your healthcare provider may prescribe a diet rich in calcium and vitamin D, a regular program of weight-bearing exercise and medical treatment.

The national osteoporosis foundation (NOF) is the nation's leading authority for patient and healthcare providers seeking up-to-date, medically sound information and educational materials of the causes, prevention, detection and treatment of osteoporosis.

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Assignment of Benefits – Appointment as Authorized Representative

I hereby acknowledge and confirm that, by signing this Assignment of Benefits ("AOB"), I have requested medical treatment, diagnostics and/or other medical or healthcare services (the "Medical Services") from Endocrinology Consultants P.C. ("the Practice") on behalf of myself and/or my dependents. I hereby assign all applicable health insurance benefits and payment (each such payment or benefit, a "Benefit") and all rights and obligations that I and any of my dependents are entitled to (or have actually received), whether it be from a private insurance payor, government source (including, without limitation, Medicaid and/or Medicare) or any other third-party payor (any of the above payment and benefit sources, an "Insurance Payor"), in connection with the Medical Services to the Practice. This authorization fully applies to any and all fees regardless of whether the Practice is in-network or out-of-network with the Insurance Payor providing such Benefit. I hereby appoint the Practice as my authorized representative (my "Authorized Representative") with the power to:

- File and process medical claims with the Insurance Payor.
- File appeals and grievances with the Insurance Payor.
- Discuss or divulge any of my personal health information or that of my dependents with any third party, including the Insurance Payor.
- Institute and pursue on my behalf any claim, right or cause of action, including any necessary litigation and/or complaints against the Insurance Payor (even to name me as a plaintiff in such action).
- Act with respect to a benefit plan governed by the provisions of ERISA as provided in 29 C.F.R. §2560.5031(b)(4) with respect to any healthcare expense incurred as a result of the Medical Services I received from the Practice and, to the extent permissible under the law, to claim on my behalf, such benefits, claims, or reimbursement, and any other applicable remedy, including fines.

I am fully aware that having health insurance does not absolve me of my responsibility to ensure that my bills for professional services from the Practice are paid in full. I also understand that I am financially responsible for any and all fees and payments associated with any and all Medical services rendered to myself and/or to my dependents (the "Fees"), including without limitation, any co-pays, coinsurance and deductibles. I understand that no guarantees have been made by the Practice or any other party in respect of any Medical Services or whether the Fees associated with such Medical Services will be paid for by any Insurance Payor and that I have the right to receive care elsewhere. I understand that I am fully responsible for any Fees due to the Practice in connection with the Medical Services that have not been actually received by the Practice for any reason, including without limitation, due to a nonpayment or claim denial by any Insurance Payor. I agree to assist the practice in its efforts to obtain payment for any Medical Services from any Insurance Payor. However, I fully understand that it is ultimately my responsibility to pay any and all Fees and to obtain any and all required authorizations, referrals and/or precertification(s) for any and all Medical Services. If my insurance plan has a pre-existing conditions clause, or requires an authorization or referral and I do not obtain one for the Medical Services I receive, I understand that I am responsible for all Fees, even if the provisions of my plan stipulate I otherwise wouldn't be. I understand that this AOB incorporates and supersedes any prior and contemporaneous understandings or agreements between the parties with respect to the subject matter of this AOB.

Authorization

I authorize the use of my signature on all insurance submissions. I authorize a copy of this document to be used in place of the original. I have read and agreed to the above and certify that the information that I have provided is correct. This Assignment of Benefits shall remain in full force and effect until there are no Fees owed to the Practice in connection with the Medical Services. **I authorize the Practice to obtain the following governing plan documents for the purposes of applicability of compliance with PPACA: (1) Summary Plan Description (SPD); (2) 5500 Form (Plan Annual report); (3) Certified Copy of Certificate for PPACA Grandfathered Plan.**

Patient Name (print): _____ Signature of Patient (or Parent/Guardian):_____

Name of Parent/Guardian (if applicable)):_____ Relationship to Patient: _____ Date:_____

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ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Endocrinology Consultants, P.C. (the "**Practice**"), and its staff and providers, may use and disclose my Protected health Information ("**PHI**") to carry out treatment, payment and healthcare operations ("**TPO**"). I understand and acknowledge that the Practice's Notice of Privacy Practices (the "**Notice**") has a more complete description of such uses and disclosures.

I permit the Practice to leave e-mail, telephone and text messages regarding my appointments, prescription renewals, lab results, and all other PHI on voicemail systems, or to provide such information to the person(s) who answer the phone, using the contact information provided.

- I agree that my PHI may be shared with my spouse (if applicable)
- I agree that my PHI may be shared with the following other people:

  _____ Relationship to Patient: _____
- I understand that I can change or revoke any of the foregoing agreements, at any time, by giving written notice to the Practice to the attention of the Privacy Officer. I understand and acknowledge that the Practice may decline to provide me with any services should I decline to sign this agreement, or should I later revoke this agreement.
- I agree that my PHI may be shared with my credit card vendor(s) if I contest any credit card charges, so that the practice can submit records to support its charges.
- I agree that the Practice may contact me at any phone numbers or email addresses provided by me regarding both PHI and non-PHI.

My signature below acknowledges that I agree with the above statements and have received the Practice's Notice and/or have been provided with an opportunity to review it.

_____ _____

Signature of Patient Date

_____

Print Name

SPOUSE/HEALTH CARE POA/LEGAL GUARDIAN
(Please circle one if signing on behalf of the patient)

FINANCIAL POLICIES

Registration: Upon scheduling and registration with Endocrinology Consultants, P.C. (the "Practice"), we require you to provide your medical insurance card (if you are utilizing its coverage, it must be brought to every visit), all third-party payor coverage information, photo identification, address, date of birth and phone number. If you receive health benefits through a spouse, partner or parent, we require you to also provide that person's full address, date of birth, and phone number. For collection purposes, we also require social security numbers. Should you be unable to produce this documentation, you may pay in full at the time of service and submit the claim to your insurance plan for reimbursement. Please notify us of changes to your insurance coverage or contact information, otherwise you may be responsible for charges we were unable to recover.

Medicare: If you have coverage with Medicare (including both original Medicare and commercial Medicare Advantage plans), it is your responsibility to understand the provisions of your health insurance plan and coverage. Every original Medicare beneficiary is responsible for an annual deductible and coinsurance. Medicare Advantage beneficiaries may be responsible for an annual deductible, coinsurance and/or a copayment. Any portion of copayment, coinsurance and deductible which is not covered by a supplemental carrier will be your financial responsibility to pay. You are wholly responsible for your coverage limitation, regardless of whether you are aware of the details. If you have both Medicare coverage and also commercial insurance, you are responsible for providing the correct primary insurance at your visit. If you have supplemental insurance that does not cross over automatically, you will be billed for the deductible and coinsurance, and you may be given a receipt to submit yourself. By signing below, you specifically agree to these terms, and exempt yourself from any protections your insurance plan may offer you regarding these provisions.

Commercial Health Insurance Plans: Although we will advise you whether we believe we participate with your insurance plan, we are not responsible for any verbal assurances made to you regarding whether particular services rendered in this Practice are covered by your plan. You and you alone are responsible to understand the provisions of your insurance plan and coverage. We recommend contacting your plan prior to receiving services in order to verify your financial responsibilities. If your insurance plan, including Medicare, issues payment to you instead of to us, you are responsible to turn the entire payment over to us immediately upon receipt together with the complete explanation of benefits form. You may be responsible for an additional balance, depending on how your insurance plan adjudicates such a claim.

Referrals: You are responsible to obtain all necessary referrals prior to your appointment, if required by your health plan and assure it is presented at the time of your visit. If your plan requires a referral, precertification or authorization that you do not obtain, your appointment may have to be rescheduled. Otherwise, if as a result your health plan refuses to pay for any claim, you explicitly agree to be responsible for our charges for any affected visits, even if the provisions of your plan stipulate you otherwise wouldn't be (you are waiving that defense). Further, it is also your responsibility to keep track of the number of visits you have used on your referral and the expiration date of your referrals and obtain new ones as needed. We will do our best to ensure you have one if you need one, but the ultimate responsibility is yours.

Cancellation/No Show Policy: If a new patient consultation has to be cancelled or rescheduled, please call the Practice forty-eight hours in advance or there will be a $75 charge. If you miss two appointments there will be a $25 charge.

Copayments, Coinsurance and Deductible: If your plan has a copayment, co-insurance or deductible, it is your responsibility to pay it at the time of service, even if the amount is not printed on your insurance card. Please have your payment ready upon check-in. We are out-of network healthcare providers with some health plans, meaning we have no contract with some health plans to participate in their network of participating providers and in many instances, they do not pay our charges for medical services in full. As a result, we have an obligation to bill our out-of-network patients their ordinary co-insurance, deductibles and cost share amounts as per your insurance agreement. If you fail to pay your coinsurance, deductibles or cost share amounts upon receipt of our invoice, you may be subject to collection activity and may be further responsible for the interest on the balance owed the Practice. However, we recognize that not all of our patients will be able to afford their patient cost share amounts. As a result, we have created a financial hardship policy which legally permits us to reduce, and in some cases, waive your patient cost share responsibility, if you qualify for the waiver. If you believe you might qualify, you may ask our staff for a copy of our financial hardship policy. Accordingly, you agree by signing this document to be responsible for your patient cost share amount, unless you qualify for financial assistance under the Practice's financial hardship policy.

Non-Payment: Any fees that are due and payable for over thirty (30) days may accrue interest at the monthly rate of thirty percent (30%). I understand that if a balance is unpaid, my account may be referred to an external collection action.

I have read, fully understand and agree with all the above policies. I fully understand and accept my financial responsibility for the charges I, or my dependents, may incur at this office.

Patient Name (print): _____ Signature of Patient (or Parent/Guardian):_____

Name of Parent/Guardian (if applicable):_____ Relationship to Patient: _____ Date: _____

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PATIENT RESPONSIBILITY
FOR FOLLOW-UP CARE PLEDGE

I, _____(print last name),_____ (print first name), hereby acknowledge and understand that even with the best training, skill and experience, a medically trained professional is not always capable of solving my medical problems. Therefore, I understand it is important that any and all recommendations by doctors are followed completely in order to increase the likelihood of a positive and healthy treatment/outcome. I acknowledge and understand that if any physician in this office prescribes medicine to me that the proper taking of any such medicine shall be my sole responsibility (or my guardian who has attended this consultation). I agree to properly follow the prescribed dosage and frequency amounts of these medicines as recommended by my doctor.

I understand that if a doctor in this office refers me to see another doctor or receive another test including, but not limited to, a blood test, an MRI, or CT Scan, this timely recommendation is important and essential to the ultimate success of my treatment/outcome. I understand that it is not possible for any person in this office to constantly follow-up to ensure that I have followed these recommendations. Therefore, I understand that if I fail to see that specialist or obtain the test for which I was referred immediately, this can risk my current health or increase future health risks.

I understand that it is solely my responsibility to follow any of the medical advice given by any medical person in this office and any bad health outcome from my failure to follow the advice of my doctors should be expected.

Signature_____ Date _____

NOTE: 1. Patient Demographic Information (N.J.S.A. 45:9-42.46(a)(1)-(4))

a. N.J.S.A. 45:9-42.46(a)(1) requires clinical laboratories to record the race, ethnicity, sexual orientation, and gender identity of each patient who presents with a non-electronic order for testing at a clinical laboratory patient service center. In other words, when a patient presents at a clinical laboratory patient service center, as defined at N.J.A.C. 8:44-2.14(b), with a paper order for a laboratory test, the clinical laboratory must capture the patient's race, ethnicity, gender identity and sexual orientation.

Please Circle the Preferred Response:

Race:

a. American Indian or Alaska Native;
b. Asian;
c. Black or African American;
d. Native Hawaiian or Other Pacific Islander;
e. White;
f. Other;
g. Unknown;
h. Asked but unknown;
i. Choose not to disclose.

Ethnicity:
a. Hispanic or Latino;
b. Non-Hispanic or Non-Latino;
c. Other;
d. Unknown;
e. Asked but unknown;
f. Choose not to disclose.

Sexual Orientation:
a. Lesbian, gay, or homosexual;
b. Straight or heterosexual;
c. Bisexual;
d. Something else, please describe;
e. Don't know;
f. Choose not to disclose.

Gender Identity:
a. Male;
b. Female;
c. Female-to-Male (FTM)/Transgender Male/Trans Man;
d. Male-to-Female (MTF)/Transgender Female/Trans Woman;
e. Genderqueer, neither exclusively male nor female;
f. Additional gender category or other, please specify;
g. Choose not to disclose.