AZ ENDOCRINE INSTITUTE PC
2971 W ELLIOT RD SUITE 1
CHANDLER AZ 85224
PH:480-733-5483
FX:480-733-7080

Dr. Seema Ahluwalila
Amanda Stewart FNP-C
Jake Wilkie PA-C
Rebecca Bustos, FNP-C

PATIENT DEMOGRAPHICS

DATE: _____

Legal Name: First _____ **MI** _____ **Last** _____ **Preferred Name:** _____

Parent / Legal Guardian Name: _____ **DOB:** _____ **Mobile:** _____

SS#: _____ **DOB:** _____ **Legal Sex:** ❑ **M** ❑ **F**

Do you have any Sexual Orientation or gender preferences you would like us to consider? ❑ **Yes** ❑ **No**

Is your Legal Sex different from your Sex at Birth? ❑ **Yes** ❑ **No**

If you answered yes to either of these questions, additional information will be collected from you later.

Address: _____ **Apt#** _____ **City** _____ **State** _____ **Zip** _____

Phone: Home _____ **Work** _____ **Mobile** _____

Email _____ ❑ **No Email**

GENERAL INFORMATION

Marital Status ❑ **Divorced** ❑ **Legally Separated** ❑ **Married** ❑ **Significant Other** ❑ **Single** ❑ **Widowed**

Need Interpreter ❑ **Yes** ❑ **No** **Preferred Language** _____ **Written Language** _____

Race: ❑ **Asian** ❑ **Black** ❑ **Native American** ❑ **Native Hawaiian/Pacific Islander** ❑ **Two or More Races** ❑ **White**

Ethnicity: ❑ **Hispanic** ❑ **Non-Hispanic**

ADDITIONAL DEMOGRAPHICS

Preferred Communication Method: ❑ **No Preference** ❑ **Mail** ❑ **Email** ❑ **Online Portal** ❑ **Accept Text Messages**
By checking one of the boxes for Preferred Communication Method, I agree to receive correspondence from DECCT.

Do you have any communication difficulties / special needs? Visually Impaired: ❑ **Y** ❑ **N** **Hearing Impaired:** ❑ **Y** ❑ **N** **Special Needs:** ❑ **Y** ❑ **N**

If yes, please list: _____

PCP

Primary Care Physician _____ ❑ **No Primary Care Physician**

EMERGENCY CONTACTS

Name _____ **Relationship to Patient** _____ **Home Phone** _____ **Mobile** _____

Name _____ **Relationship to Patient** _____ **Home Phone** _____ **Mobile** _____

EMPLOYMENT

Employer Name _____ **Employment Status:** ❑ **Disabled** ❑ **Full Time** ❑ **Part Time** ❑ **Retired** ❑ **Student** ❑ **Unemployed**

FOR OFFICE USE ONLY:

Patient Name _____
MRN _____

OPTIONAL AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION TO OTHERS

I authorize Az Endocrine Institute PC to use the additional contact information listed below to discuss or disclose information regarding any matters relating to my appointments, billing information and/or medical care. This authorization will remain in effect until I provide written notification to Az Endocrine Institute PC of changes or updates. I also authorize Az Endocrine Institute PC to use the additional contact information listed below to discuss or disclose information regarding any matters relating to my
insurance or test results.

❑ **Only Release Information to Patient**

If *no* answer, may we leave a message on your: Home Phone ❑ Y ❑ N Work ❑ Y ❑ N Mobile ❑ Y ❑ N

Name _____ **Relationship to Patient** _____

Home Phone _____ May We Leave a Message? ❑ Y ❑ N Mobile _____ May We Leave a Message? ❑ Y ❑ N

You may release the information regarding the following services to the person named above: ❑ Appointments ❑ Billing ❑ Medical Care

Name _____ **Relationship to Patient** _____

Home Phone _____ May We Leave a Message? ❑ Y ❑ N Mobile _____ May We Leave a Message? ❑ Y ❑ N

You may release the information regarding the following services to the person named above: ❑ Appointments ❑ Billing ❑ Medical Care

If you wish to receive your health information by email, the information will be sent via encrypted email unless you expressly designate otherwise below. Sending health information by unencrypted email may pose some risk that the health information in the unencrypted email could be read by a third party over the internet.

Initials _____

FINANCIALLY RESPONSIBLE PARTY - GUARANTOR

❑ **Same as Patient Information (If different, please complete section below)**

Name: First _____ MI _____ Last _____ DOB _____

Relationship (Please circle): Spouse Father Mother Other (Please Specify) _____

Address: _____ Apt# _____ City _____ St _____ Zip _____

Phone: Home _____ Cell _____ Work _____

Employer Name _____ Employment Status: ❑ Student ❑ Part Time ❑ Full Time ❑ Retired ❑ Disabled ❑ Unemployed

INSURANCE INFORMATION

PRIMARY INSURANCE _____ **ID** _____ **GRP#** _____

Subscriber Name _____ Sex: ❑ M ❑ F Patient Relationship to Subscriber _____

Subscriber DOB _____ **Phone:** Home _____ Cell _____ Work _____

Employer Name _____ Employment Status: ❑ Student ❑ Part Time ❑ Full Time ❑ Retired ❑ Disabled ❑ Unemployed

SECONDARY INSURANCE _____ **ID** _____ **GRP#** _____

Subscriber Name _____ Sex: ❑ M ❑ F Patient Relationship to Subscriber _____

Subscriber DOB _____ **Phone:** Home _____ Cell _____ Work _____

Employer Name _____ Employment Status: ❑ Student ❑ Part Time ❑ Full Time ❑ Retired ❑ Disabled ❑ Unemployed

FOR OFFICE USE ONLY:

Patient Name _____
MRN _____

HOW YOU HEARD ABOUT US

❑ Family Friend ❑ Email ❑ Newspaper/Magazine Ad ❑ Organization Website ❑ Internet Search ❑ Television Commercial ❑ Organization Newsletter
❑ Other _____ ❑ Referring Physician _____ ❑ Coach _____ ❑ Trainer _____

FINANCIAL AND PAYMENT GUIDELINES

Notice: Our office does NOT file Auto Insurance claims for visits relating to motor vehicle accidents.

Payment is due at the time of service. This includes all co-pays, deductibles, and co-insurance. If your insurance company requires a referral, it is the patient's responsibility (or guarantor) to obtain the referral prior to your appointment.

- I authorize direct payment of my insurance benefits to Az Endocrine Institute PC for services rendered to myself or dependents. Insurance will be filed for services rendered. Any charges for services not covered by insurance will be the responsibility of the
- patient or his/her guardian. I understand that it is my responsibility to know my insurance benefits and whether the services rendered are covered benefits.
- Patient or guardian is responsible for notifying our office of any changes to demographics or insurance and billing information.Out-of-
- Network services not paid for by the health insurance company will be the responsibility of the patient or his/her guardian. Az Endocrine Institute PC, or its authorized agent, will provide medical information to the insurance company as required for payment of claims for services rendered.
- I hereby consent to credit bureau inquiries and to receiving auto-dialed/artificial or pre-recorded message calls, and/or text messages to my cellular telephone and to my telephone number provided during my registration process. I understand that these collection attempts could be performed by Az Endocrine Institute PC, or its affiliates/agents including, without limitation, any account management companies, independent contractors or collection agents.

Lab / X-Ray / Diagnostic Services:

- I understand that I may receive a separate bill if my medical care includes lab, x-ray, or any other diagnostic services. I further understand that I am financially responsible for any co-pays, deductibles and co-insurance due for these services if they are not reimbursed by my insurance.

RELEASE OF INFORMATION, AUTHORIZATION & ASSIGNMENT OF BENEFITS

I authorize the release of all medical records to specialists and/or consulting physicians if applicable to my care and condition.

- I authorize any holder of medical or other information about me to release to the Social Security Administration, Health Care Financing Administration, its intermediaries, its carriers, or any other insurance carrier any information needed for this or any other claim to be processed. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to me or to the party who accepts assignment. I understand it is mandatory to notify the health care provider of any party who may be responsible for paying for my treatment.
- I further authorize and request that insurance payments be directed to Az Endocrine Institute PC.

PRIVACY PRACTICES

Az Endocrine Institute PC offices, physicians, and staff are committed to securing the privacy of your health information. We are making available to you a copy of our Notice of Privacy Practices.

ACKNOWLEDGEMENT

I have read, and fully understand and agree to, the above release of medical information to others, financial and payment guidelines, release of information & assignment of benefits, authorization to treat a minor, and privacy practices. I also certify that all the information provided is complete and accurate.

Patient Name _____ Signature _____ Date _____

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Consent to Treat

I hereby authorize employees and agents of Az Endocrine Institute PC (including physicians, physician assistants, and nurse practitioners, and other employees and staff members) to render medical evaluations and care to the patient indicated below. I understand that, in connection with the patient's treatment, photos or videos may be taken. The duration of this consent is indefinite and continues until revoked in writing. I understand that, by not signing this consent, the patient will not be provided medical care except in the case of emergency.

Today's Date: _____

Print Patient's Name: _____

Patient Date of Birth: _____

Legal Guardian (if different than patient):

_____

Patient or Legal Guardian Signature:

_____

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MEDICAL HISTORY FORM

This form is confidential and will become part of your medical record

Name: _____ Date: _____

Address: _____ Date of Birth: _____

Referring Provider/Primary Care Provider: _____

PLEASE DESCRIBE THE REASON FOR THE VISIT:

_____
_____
_____
_____
_____
_____
_____

PAST SURGERIES:

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

PERSONAL MEDICAL HISTORY:

Do you have, or have you had, any of the following? Please check all which apply and write approximate dates of procedures or diagnosis:

DIAGNOSIS	DATE (Month/Year)
❑ Diabetes	_____
❑ High Blood Pressure	_____
❑ High Cholesterol ❑ Triglycerides	_____
❑ Heart Attack / Coronary Bypass / Stent	_____
❑ Heart Failure	_____
❑ Strokes / Mini-Strokes	_____
❑ Overactive Thyroid	_____
❑ Underactive Thyroid	_____
❑ Thyroid Nodules / Tumors	_____
❑ Thyroid Cancer	_____
❑ Osteoporosis	_____
❑ High / Low Calcium	_____
❑ Bariatric (obesity) Surgery	_____
❑ Sexual Hormone Deficiencies	_____
❑ other Medical Problems:	_____
_____	_____
_____	_____
_____	_____
_____	_____

PHARMACY INFORMATION:

Pharmacy Name: _____
Address: _____
Pharmacy Phone #: _____

ALLERGIES:

Are you allergic to any medications, supplements or foods? Please list below:

_____	_____
_____	_____
_____	_____
_____	_____

PERSONAL HABITS:

Do you currently use tobacco? ❑ Yes ❑ No
If yes, how much and how often? _____

Are you an Ex-Smoker? ❑ Yes ❑ No
How long ago did you quit? _____

Do you use alcohol? ❑ Yes ❑ No
If so, how much per week? _____

Do you use recreational drugs? ❑ Yes ❑ No
If so, how much per week? _____

FAMILY HISTORY:

Do any First-Degree relatives suffer, or have previously suffered, from the following condition(s)?

CONDITION	FAMILY MEMBER
❑ Diabetes	
❑ Heart Attacks	
❑ Heart Failure	
❑ Strokes	
❑ High Cholesterol	
❑ Cancer	
❑ Amputations	
❑ Renal Failure	
❑ Blindness	
❑ Thyroid Disease	
❑ Thyroid Surgery	
❑ Other Serious Diseases or Conditions:	

FOR ALL PATIENTS:
Do you have any of the following condition(s)?

- ❑ Cough Lasting Over 7 Days
- ❑ Fever
- ❑ Night Sweats
- ❑ Positive Skin TB Test
- ❑ Abnormal Chest X-Ray
- ❑ History of Tubercolis
- ❑ Exposure to Somebody with Tubercolis

DIABETIC PATIENTS:

Do you check your blood sugar at home? _____
If Yes, how often? _____
(Please have your results or your meter available)

When was your last DIABETIC EYE EXAM? _____
Name of Eye Doctor: _____
Are you following a DIET or NUTRITIONAL Plan? _____
If Yes, please describe:

_____

Have you ever received DIABETES EDUCATION or CLASSES? If yes, when and where?
_____ / _____

Have you ever participated in a RESEARCH STUDY on Diabetes? _____

Would you be interested in learning more about RESEARCH STUDIES in Diabetes? _____

DO YOU EXPERIENCE ANY OF THE FOLLOWING?

- ❑ Excessive Thirst
- ❑ Excessive Urination
- ❑ Nocturnal Urination
- ❑ Low Blood Sugars
- ❑ Kidney Problems
- ❑ Dry Mouth
- ❑ Frequent Infections
- ❑ Foot Infections
- ❑ Foot Ulcers or Wounds
- ❑ Sexual Dysfunction
- ❑ Dizziness Upon Standing
- ❑ Chest Pain
- ❑ Shortness of Breath
- ❑ Swelling on Your Legs
- ❑ Numbness or Tingling, where? _____
- ❑ Burning Pain, where? _____
- ❑ Recent Weight Gain, how much? _____
- ❑ Recent Weight Loss, how much? _____
- ❑ Vision Problems
- ❑ Poor Balance
- ❑ Falls
- ❑ Nausea / Vomiting
- ❑ Dental or Gum Problems
- ❑ Other Problems: _____

FOR WOMEN OF CHILD-BEARING AGE:

Are you pregnant or may you be pregnant? _____
Last Menstrual Period: _____ / _____ / _____
Do you have Tubal Ligation? _____ Hysterectomy? ____

Please ask the receptionist if you need an additional sheet of paper.

" I attest that the information provided is true and complete to the best of my knowledge. I understand that INTENTIONALLY PROVIDING FALSE OR MISLEADING INFORMATION may result in the TERMINATION of the patient-provider relationship."

Signature of Patient or Legal Guardian:

_____ Date: _____

Name (PRINT) *:*

_____

MEDICATIONS AND SUPPLEMENTS LIST (include INSULIN)

Please bring all your medications or an updated list to every visit. FOR YOUR SAFETY, let the nurse or the physician know of ANY changes in your medications or ANY NEW medications. Some medications can cause serious adverse effects when mixed with other medications or supplements. *In order to avoid dangerous interactions, we need to know **EVERYTHING** you are taking.*

Name: _____ *DOB:* _____ *Date:* _____

Medication name and form (tablet, vial, capsule, pen, etc.)	**Strength if known**	**How often?**	**How do you take it?** i.e. by mouth, injection, etc.	**Prescriber**

You can download a new Medication List at any time from our website: azendocrineinstitute.com