**The Diabetes Center, P.L.L.C.**
**1278 Ocean Springs Rd**
**Ocean Springs, MS 39564**

# NEW PATIENT INFORMATION

## PERSONAL INFORMATION

Name:____________________________________ DOB:_______________ SS#________________________

Address:_____________________________________________________________________________________

City:_______________________________________ State:__________ Zip Code: _________________________

Race: ______________ Ethnicity: Non-Hispanic______ Hispanic______ If Hispanic, specify: ________________

Sex: Male_______ Female________ Email: _______________________________________________________

Home Phone: __________________ Work Phone: ____________________Cell Phone: __________________

Emergency Contact Person:_____________________________________ Phone: ________________________

## EMPLOYMENT INFORMATION

Employer: __________________________________________________

Employer Address: ____________________________________________Employer Phone:__________________

## INSURANCE AND PAYMENT INFORMATION

Primary Insurance Company:_______________________________________________________________

Policy #: ____________________________Name of Guarantor:___________________________________

Secondary Insurance Company:_____________________________________________________________

Policy#:_____________________________ Name of Guarantor: ___________________________________

Who is responsible for this bill?__________________________________________________________

I understand and agree that, regardless of my insurance status, I am responsible for the balance of my account for any professional services rendered. I also understand that if I have a co-pay I will pay it at the time of my visit. I agree to pay all costs of the collection, including reasonable attorney fees and court costs in the event it becomes necessary to pursue the account for collection.

I agree to pay a $25 fee in the event that I do not show up for my appointment or cancel within 24 hours.

I have read and understand all of the above information and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information.
A photocopy of the Assignment shall be considered as effective and valid as the original.
I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in the case.
I authorize doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

______________________________________ ________________________

Signature of Patient Date

# HISTORY OF PRESENT ILLNESS

**If you were referred by a doctor, what doctor referred you?** ________________________

**Who is your Primary Care Physician?**_____________________

**Please list medication ALLERGIES and type of reaction:**

| MEDICATION | REACTION |
|---|---|
| | |
| | |
| | |

**Please list all CURRENT MEDICATIONS:**

| MEDICATION | DOSE | HOW OFTEN IS MED TAKEN |
|---|---|---|
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Please select ANY of the following conditions related to your PAST MEDICAL HISTORY:

| **CARDIOVASCULAR** | | | **ALLERGY/DERMATOLOGIC** | |
|---|---|---|---|---|
| Atrial fibrillation | | | Seasonal Allergies | |
| Defibrillator | | | Psoriasis (skin disease) | |
| Congestive heart failure | | | Frequent sinusitis | |
| Blood clots | | | **NEUROLOGICAL** | |
| Angina (chest pain) | | | Stroke | |
| Heart attack | | | Alzheimer's | |
| Balloon or Stent | | | Spinal disc disorder | |
| High cholesterol | | | Migraine headaches | |
| High triglycerides | | | Tension headaches | |
| High blood pressure | | | Meningitis | |
| Irregular heartbeat | | | Multiple Sclerosis | |
| Aneurysm | | | Parkinson's Disease | |
| Stress test DATE: | | | Neuropathy | |
| Heart catheter DATE: | | | Seizure disorder | |
| **RESPIRATORY** | | | Mini-stroke | |
| Asthma | | | **ENDOCRINE** | |
| Chronic bronchitis/COPD/Emphysema | | | *** ***Type 1 Diabetes*** | |
| Pneumonia | | | *** ***Type 2 Diabetes*** | |
| Blood clot to lung | | | Cushing's Disease | |
| Sleep apnea | | | Hyperthyroidism (overactive) | |
| Tuberculosis (TB) | | | Hypothyroidism (underactive) | |
| **GASTROINTESTINAL** | | | Osteoporosis | |
| Stones of the gallbladder | | | Goiter | |
| Disease of the liver | | | **HEMATOLOGIC** | |
| Polyp of the colon | | | Pernicious anemia | |
| Crohn's Disease | | | **CANCER** | |
| Reflux | | | Brain tumor | |
| Hepatitis | | | Breast cancer | |
| Irritable bowel | | | Cervical cancer | |
| Inflammation of pancreas | | | Colon cancer | |
| Peptic ulcer disease | | | Uterine cancer | |
| Ulcerative colitis | | | Liver cancer | |
| **G-U/REPRODUCTIVE** | | | Leukemia | |
| Chronic renal failure | | | Lung cancer | |
| Glomerulonephritis | | | Lymphoma | |
| Recurrent urinary tract infections | | | Melanoma | |
| Kidney stones | | | Ovarian cancer | |
| **MUSCULOSKELETAL** | | | Kidney cancer | |
| Fibromyalgia | | | Skin cancer | |
| Chronic Fatigue Syndrome | | | Other cancer(s): | |
| Fracture(s) List if any: | | | **OTHER** | |
| | | | | |
| Gout | | | | |
| Osteoarthritis | | | | |
| Polymyalgia Rheumatica | | | | |
| Rheumatoid Arthritis | | | | |

# Past Medical History (cont'd)

**Please check any of the following that you have ever had:**

| PSYCHOLOGICAL | | | SURGERIES YOU HAVE HAD & DATE |
|---|---|---|---|
| Anxiety | | | |
| Anorexia Nervosa | | | |
| Bipolar Disorder | | | |
| Bulimia | | | |
| Depression | | | |
| Obsessive-Compulsive Disorder | | | |
| Schizophrenia | | | |
| **EYES** | | | |
| Cataracts | | | **NAME OF YOUR CURRENT DOCTORS** |
| Glaucoma | | | |
| **GYNECOLOGICAL** | | | |
| History of endometriosis | | | |
| Polycystic Ovarian Disease | | | |
| HIV (+) | | | |
| AIDS | | | |

## FAMILY HISTORY

**<u>Please use these abbreviations to indicate your FAMILY history for each individual:</u>**

Father (F) Mother (M) Brother (B) Sister (S)

Bypass Surgery ______________________
High Cholesterol ______________________
Heart Attack ______________________
High Blood Pressure ______________________
Balloon Surgery ______________________
Thyroid Issues ______________________
Cancer ______________________

Kidney Stones ______________________
Aneurysm ______________________
Alzheimer’s disease ______________________
Stomach Ulcers ______________________
Stroke ______________________
Diabetes ______________________
Menopause before age 40 ______________________

## SOCIAL HISTORY

Marital Status: Single Married Divorced Widowed Other:__________

Exercise: Never Seldom Daily Weekly Type of exercise:_____________________________

## HABITS

Tobacco: Never smoked Past tobacco use Current tobacco use
Date Quit:____________ Cigarettes per day:_____________

Alcohol: Non-drinker Rare Social Regular use:________________

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Medicare Only:
I, ________________________________, understand that I am responsible for any balance on my account that is not paid by Medicare. I realize this may include charges for any office visits, lab tests, or procedures incurred with The Diabetes Center, P.L.L.C.

________________________________ ________________________________ ____________
Patient Printed Name Patient Signature Date

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## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PROVIDER PRIVACY PRACTICES & FINANCIAL POLICY AGREEMENT

**I acknowledge that I have received a copy of the current 2003 Health Information Portability and Accountability Act of 1996 (HIPPA) guidelines. I also acknowledge that I have received a copy of the current The Diabetes Center, P.L.L.C. Financial Policy and understand them in their entirety.**

______________________________ ______________________________ ____________
Printed Name Patient Signature Date

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## PATIENT INFORMATION CONSENT FORM

I, __________________________________, give my consent to The Diabetes Center to release medical information such as test results, prescription changes, appointment dates and times, as well as billing/insurance information to the following persons listed below.

| NAME | RELATIONSHIP TO PATIENT | CONTACT INFO |
|---|---|---|
| ____________________________ | ____________________________ | ________________________ |
| ____________________________ | ____________________________ | ________________________ |
| ____________________________ | ____________________________ | ________________________ |

This release will stay in effect indefinitely from the date signed or until the patient states otherwise in writing to this office.

________________________________ ________________________________ ____________
Patient Printed Name Patient Signature Date

________________________________ __________________
Employee Witness Signature Date

Diabetes History:

- Date diabetes was first diagnosed: ___________________________

- How many times do you get up to urinate during the night? ________

- Do you have any of the following sensations in your feet or hands?
  (please check all that apply):
  ___numbness
  ___ tingling
  ___ burning
  ___ NONE OF THE ABOVE
- Do you have a full stomach a long time after eating? Yes No

- Previous treatment for diabetes has included: (check all that apply)
  _____No prior medications
  _____Micronase, Diabeta, Glynase, Amaryl, Prandin, Precose
  _____Avandia
  _____Actos
  _____Glucophage
  _____Insulin ______________
  _____Other ______________

- Has the eye doctor mentioned Diabetes has affected the blood vessels of your eyes? Yes No
- Have you been told you have protein in your urine? Yes No

- Do you have high blood pressure? Yes No
- Do you have high cholesterol? Yes No
- Do you have high triglycerides? Yes No

- Have you had foot ulcers? Yes No
- Have you had foot infections? Yes No

- How often do you have low blood sugar reactions? (please check one)
  ______Not at all
  ______Seldom
  ______Frequently

- When was your last visit to an ophthalmologist (eye doctor)? _________________________________
- How often do you check your own feet for a callus, ulcer, cuts, sores, etc? ______________________
- How often do you check your blood sugar? (please check)
  ____2 times per day
  ____3 times per day
  ____4 times per day
  ____weekly
  ____Other ___________

  **My blood sugar ranges from ________ to ___________

- What kind of diabetes education have you received? (please circle all that apply)
  ____Talked with dietitian
  ____Previous diabetes individual classes
  ____Previous diabetes group classes
  ____Other
  ____ NONE

Please select if you are experiencing any of the following:

**Constitutional**
__ fatigue
__ fever
__ weight gain (___ lbs in ___ weeks)
__ weight loss (___lbs in ___ weeks)

**Eyes**
__ blurred vision
__ wear glasses/contacts

**Ears/Nose/Throat**
__ hearing problems
__ wear dentures
__ hoarseness
__ frequent yeast infections of mouth

**Cardiovascular**
__ chest discomfort on exertion
__ pain in calves when you walk
__ sleep propped up
__ heart skipping
__ swelling of feet/ankles
__ rapid heart beat

**Respiratory**
__ cough (chronic)
__ shortness of breath on rest

**Gastrointestinal**
__ abdominal pain
__ difficulty swallowing
__ constipation
__ diarrhea
__ nausea
__ vomiting

**Genitourinary**
__ burning on urination
__ blood in urine
__ history of frequent UTI's
__ get up at night to urinate
__ excessive urination

**Musculoskeletal**
__ pain in joints
__ back pain
__ joint stiffness
__ limb pain
__ muscle pain

**Integumentary**
__ acne
__ dry skin
__ fungal nail infection
__ rashes

**Neurological**
__ dizziness
__ fainting
__ headaches
__ memory loss
__ tremor
__ spinning sensation
__ weakness

**Hematologic/Lymphatic**
__ easy bruising
__ swelling of lymph glands

**Endocrine**
__ Heat/Cold intolerance
__ increasing facial hair
__ increased skin pigmentation
__ infertility
__ excessive thirst
__ excessive hunger
__ excessive sweating

**Psychiatric**
__ anxiety
__ depression
__ feeling stressed
__ poor concentration
__ recreational drug use
__ sleep disturbance

****FEMALE ONLY:**
__ painful menstruation (period)
__ irregular menstrual cycle
__ history of frequent yeast infections
__ vaginal itching
__ perform self breast exams
__ nipple discharge
__ hot flashes
__ mood swings