Peconic Endocrinology
Barbara Gredysa, MD
Phone: 631-740-9273 Fax: 631-740-9275 Email: peconicendo@optonline.net

Date:_____ Date of Birth:_____SS#:_____

Name:_____ **Phone**:_____**Cell Phone**:_____

Address:_____ **Email**:_____

_____

Please list all medication with dosage /Frequency. If more space is required, please attach a separate list.

1._____ dose/freq _____ 2._____ dose /freq_____

3. _____ dose/freq _____ 4._____ dose/freq _____

5. _____ dose/freq _____ 6. _____ dose/freq _____

Pharmacy: _____**City**: _____ **Phone**: _____

List Allergies:

_____

If no allergies write NONE

Past Medical History:

Diabetes ☐ Thyroid Disorder ☐ Asthma ☐

Overweight/Underweight ☐ Blood Clot ☐ Vascular Disease ☐

Liver Disease ☐ Osteoprosis/Osteopina ☐ Parathyroid Disease ☐

Coronary Artery Disease ☐ COPD ☐ Pituitary Disorder ☐

Hypertension ☐ Seizure ☐ Adrenal Disorder ☐

Glaucoma ☐ Cancer _____ type Other: Explain

Heart Disease ☐ Emphysema ☐ _____

Family History:

Cancer _____	Mother ☐	Father ☐	Sibling ☐	Other: _____
Heart Disease	Mother ☐	Father ☐	Sibling ☐	_____
Diabetes	Mother ☐	Father ☐	Sibling ☐	_____
Thyroid Disease	Mother ☐	Father ☐	Sibling ☐	_____
High Cholesterol	Mother ☐	Father ☐	Sibling ☐	_____
Hypertension	Mother ☐	Father ☐	Sibling ☐	
Stroke	Mother ☐	Father ☐	Sibling ☐	
Hormonal Disorders	Mother ☐	Father ☐	Sibling ☐	
Coronary Artery Disease	Mother ☐	Father ☐	Sibling ☐	

Have you ever had a bone density study performed? ☐ Yes ☐ No

Date/Location of study: _____

Past Surgical History: Please list procedure with date

_____

_____

Social History:

Do you Drink Alcohol? ☐ Yes ☐ No **How often?** Daily ☐ Weekly ☐ Monthly ☐ Occasionally ☐

_____

Drugs? ☐ Yes ☐ No **What kind and how often**? _____

Do you smoke? ☐ Yes ☐ No ☐ Current Smoker ☐ Non Smoker

Former Smoker–When did you quit smoking? _____

***Race**: ☐ White ☐ Asian ☐ Black ☐ Hispanic ☐ American Indian

***Ethnicity:** Latino ☐ Not Latino ☐ ***Primary Language** _____

Primary Physician:_____ **Referring Physician**:_____

Primary Health Insurance:_____ **Policy #**:_____

Who is the policy under? Self ☐ Spouse ☐ Parent ☐ Other:_____

Policyholder Name:_____ Policyholder Date of Birth: _____

Secondary Health Insurance:_____ Policy #:_____

Who is the policy under? Self ☐ Spouse ☐ Parent ☐ Other:_____

Policyholder Name:_____ Policyholder Date of Birth: _____

Emergency Contact:_____ **Phone Number**:_____
Relationship:_____

Employer _____ **Address**_____

Phone # _____ **Position** _____

Signature _____ **Date** _____

Peconic Endocrinology

Financial Policy

At Peconic Endocrinology, we believe in providing the best medical care possible. For us to provide you with the highest quality medical care, we must ensure that we are able to meet the expenses necessary to operate this facility. Due to the wide variety of insurance plans and the changes in the healthcare system, we have implemented the following policies effective June 2020.

Patient responsibility: We require that you pay all portions not covered by your insurance due to deductible, co-payments, coinsurance, and cost share. As a courtesy to you, we will call your insurance company to verify basic benefits: however, your insurance policy is a contract between you and your insurance company. Due to the wide variety of insurance plans and increasing in-network deductibles we will estimate a patient's cost share, but the final amount will be determined by your insurance company.

Cancellation Policy: Any appointment not cancelled within 48 hours will be subject to a $50.00 cancellation Fee.

Referrals: Any visit that requires an insurance plan referral from a primary care physician will be the responsibility of the patient to request from their primary providers. Any denial from your insurance for lack of referral will be your financial responsibility. _____ **Initial**

Labs: All labs and testing ordered by Peconic Endocrinology **MUST** be done at least **7 days** prior to your appointment. Failure to do so will result in your appointment being rescheduled and may also result in a cancellation fee.
_____**initial**

Credit Card Authorization Form:

A secure method of payment for the portion of services that your insurance applies to patient responsibility. Your credit card information is kept confidential and secure and payments to your card are processed only after the claim has been processed by your insurance carrier. Once the insurance has determined what your financial responsibility is, we will run your credit card and mail you a copy of the receipt and explanation of benefits. If your insurance is not in effect at the time of service, you will be charged as a self-pay.

Credit Card Information:

Card Type: ☐ **MasterCard** ☐ **VISA** ☐ **Discover** ☐ **AMEX** **Other: _____**

Cardholder Name (shown on card): _____

Card Number: _____

Expiration Date(mm/yy): _____

Cardholder ZIP Code (from credit card billing address): _____

I, _____, authorize Peconic Endocrinology to charge my credit card above for Insurance Copays, Deductibles and Coinsurances that my insurance deems patient responsibility for all medical services performed.

By signing below, I acknowledge that I have read and agree to the terms above.

Print Name _____**Signature** _____**Date** _____

Revised August 2021

Peconic Endocrinology, P.C. - Privacy Practices Summary

This notice summarizes how medical information about you may be used and disclosed and how you can get access to this information. Please read it carefully. You may request a written copy as well.

Our responsibilities:

We are required to:

· Maintain the privacy of your personal health information.
· Provide you with this notice of our legal obligations and privacy practices with respect to the information we collect and maintain about you.
· Abide by the terms of our Privacy Practice Notice.

Your rights:

As a patient you have several rights regarding your personal medical information, including the following:

· The right to request that we do not use or disclose your medical information in certain ways.
· The right to request to receive communication in an alternative manner.
· The right to inspect and obtain a copy of your health information.
· The right to request an amendment to your health information.
· The right to an accounting of certain disclosures of your health information.

We reserve the right to change our privacy practices and make the new provisions effective for all personal health information we maintain. Should we make material changes, we will post it in a clear and prominent location and make the revised notice available to you upon request.

I acknowledge that I have read and understand the Notice of Privacy Practices for Peconic Endocrinology. I also understand that I can contact the office by phone, at 631-740-9273 with any questions.

On Contact Privacy:

Our office may call about appointments, billing matters, or to leave a message to contact the office. We will not leave personal medical information such as test results or diagnoses or prognoses in a message. If you are not available when we call, please indicate how we may leave a message for you:

1. Peconic Endocrinology may leave a message for me on my answering machine or voice mail at the phone number I have provided. ☐ **Yes** ☐ **No**

2. Peconic Endocrinology may leave a message with anyone who answers the phone at the number I have provided. ☐ **Yes** ☐ **No**

AUTHORIZATION TO RELEASE INFORMATION:

I authorize Peconic Endocrinology to release all medical information to my Primary and/or Referring Physician. Please list any other person(s) authorized to receive your medical information

NAME_____**RELATIONSHIP** _____

NAME_____**RELATIONSHIP** _____

Signature _____ _____ **Date** _____