CHANDLER ENDOCRINOLOGY

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Date: _____

Patient First Name: _____ **MI**____ **Last Name:**_____

Mailing Address: _____ **Apt/Unit #:**_____

City: _____ **State:** _____ **Zip:** _____

Primary phone □ cell □ home: _____ **Secondary phone □ cell □ home:** _____

SS#: _____ **Date of Birth:** _____ **Marital Status: M S D W**

Sex: Female Male Employer's Name: _____

Patients Email Address:_____

Race: _____ **Ethnicity:** _____ ☐ **Decline To Provide Race/Ethnicity**

REQUIRED:: Emergency Contact Name: _____
Phone Number: _____ **Relation:** _____

HOW DID YOU HEAR ABOUT US?

□ **Physician's Name** _____ □ **Bing** □ **Yelp.com** □ **Family/Friends** □ **Yahoo**
□ **Vitals.com** □ **Google** □ **Insurance** □ **Healthgrades.com**

Primary Insurance Name: _____
Policy Holder Name: _____ **SSN:** _____ **Date Of Birth:**_____
Phone #: _____ **Policy Holder Employer:** _____
ID Number: _____ **Group/Policy #:** _____

Secondary Insurance Name: _____
Policy Holder Name: _____ **SSN:** _____ **Date Of Birth:** _____
Phone #: _____ **Policy Holder Employer:** _____
ID Number: _____ **Group/Policy #:** _____

We bill your insurance company as a courtesy to you. It is your responsibility to know your benefits, and you are ultimately responsible for payment if a service is not covered for any reason including not obtaining a referral from your PCP. Please be prepared to make a payment or co-payment at the time of service. Thank you

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

Please give a brief description for your visit today: _____
_____

MEDICAL HISTORY

Do you or have you ever had any of the following problems?

Diabetes **Yes No Don't Know**
If yes, What type? _____
If yes, any complications (eye, kidney, nerve or foot problems)? _____
If yes, date of last eye appointment? _____ **If yes, date of last HgA1C** _____

Heart Disease **Yes No Don't Know**
High Blood Pressure **Yes No Don't Know**
High Cholesterol **Yes No Don't Know**
Thyroid Disease **Yes No Don't Know**
If yes, what type? _____
(Low or high thyroid levels, goiter, thyroid nodule, or thyroid cancer)
Pituitary Problem **Yes No Don't Know**
Adrenal Problem **Yes No Don't Know**
Osteoporosis **Yes No Don't Know**
Kidney Stones **Yes No Don't Know**

Menstrual Problems **Yes No Don't Know** **Last Cycle:** _____
If so, what type? _____

Other Medical Problems (Please List)

_____ _____ _____
_____ _____ _____

Medication Allergies

☐ **No Known Allergies**

☐ **Aspirin** ☐ **Codeine** ☐ **Sulfa** ☐ **Penicillin**

☐ **Latex** ☐ **Keflex** ☐ **Other** _____ _____ _____

To the best of my knowledge, the above information is correct. I understand it is my responsibility to inform my doctor if I or my minor child ever has a change in health. I understand when my insurance is billed and if my claim is denied due to other active coverage or denied for any inaccurate information that I have provided I will be fully responsible for all charges incurred at the time of the visit.

_____ _____
Signature of Patient or Legal Guardian Date

_____ _____
Please Print Name of Patient or Legal Guardian Relationship to Patient