Diabetes, Endocrinology & Lipidology Center, Inc.

Thank you for scheduling an appointment with our office to see Dr. Philip J.A. Ryan. If you find the date and time that you have scheduled is not convenient for you, please give our office a call as soon as possible so we can change your appointment. Since this will be your first appointment at our practice, please plan on being here for at least 60-90 minutes. Kindly give a twenty-four hour notice if you are unable to keep this appointment. You will be charged a fee if this notice is not given in the appropriate time frame.

Our office is located at 176 Health Care Lane, Suite B, Martinsburg, WV 25401. Health Care Lane is off Tavern Road, near MediCap Pharmacy.

You will be contacted by our office 1-2 business days prior to your scheduled date to confirm your appointment.

Thank You,
Diabetes, Endocrinology & Lipidology Center, Inc

176 Health Care Lane, Suite B, Martinsburg, WV 25401
phone: 304.260.1060 fax: 304.260.1062 email: DELC@delc.me

Diabetes, Endocrinology & Lipidology Center, Inc.

Dear New Patient,

We are happy that you have chosen to become a patient of ours at the *Diabetes, Endocrinology & Lipidology Center, Inc.* At DELC, we believe in providing the best medical care possible to our patients. With this being said, we ask that you please bring any information regarding the reason why our providers are seeing you. This includes any recent lab results or test results that will help us with your care.

Enclosed you will find a yellow patient questionnaire that is detailed. It is **crucial** that you have the **entire** questionnaire filled in prior to your appointment date. **If you arrive to your appointment and this is not completed, we will have to reschedule your appointment!** This questionnaire helps our providers with giving you the best possible care that you deserve.

We ask that you please bring the following items with you to your visit:

- Photo identification (If the patient is a minor, we will ask for the parent/guardian's photo identification)
- Current medical insurance card
- Insurance referral form from your primary care physician, *only if required by your insurance plan (this includes UniCare)*
- List of medications you are currently taking (if taking any). *Please include the dosage and frequency the medicine is being taken.*
- **All** of the paperwork we have sent to you today.

We look forward to seeing you on your scheduled appointment date. If you have any questions before then, please do not hesitate to call us on (304) 260-1060!

Sincerely,
Diabetes, Endocrinology & Lipidology Center, Inc.

176 Health Care Lane, Suite B, Martinsburg, WV 25401
phone: 304.260.1060 fax: 304.260.1062 email: DELC@delc.me

Philip J.A. Ryan, M.D.

DATE: _____

PATIENT'S PERSONAL HISTORY

PATIENT NAME: _____ DATE OF BIRTH: _____

What are your major problems or symptoms? List in order of importance:

1. _____
2. _____
3. _____
4. _____

FAMILY HISTORY:

NAME	IF LIVING		IF DECEASED	
	AGE	HEALTH	AGE AT DEATH	CAUSE
FATHER				
MOTHER				
BROTHERS/SISTERS (CIRCLE SEX)				
M F				
M F				
M F				
M F				
M F				
HUSBAND/WIFE				
SONS/DAUGHTERS (CIRCLE SEX)				
M F				
M F				
M F				
M F				
M F				
M F				

FAMILY HISTORY:

Check if any blood relative has or has had any of the following and enter relationship.

	YES	NO	WHO?		YES	NO	WHO?		YES	NO	WHO?
Stroke	☐	☐		Osteoporosis	☐	☐		Depression	☐	☐	
Cancer	☐	☐		Obesity	☐	☐		Adrenal Disorders	☐	☐	
High Blood Pressure	☐	☐		Migraine	☐	☐		Goiter/Thyroid	☐	☐	
Pre-diabetes	☐	☐		Asthma/Allergies	☐	☐		Arthritis	☐	☐	
Diabetes	☐	☐		Heart Attack	☐	☐		Nervous Breakdown	☐	☐	
Hypoglycemia	☐	☐		Stomach Ulcers	☐	☐		Gout	☐	☐	
Glucose Intolerance	☐	☐		Kidney Disease/Stones	☐	☐		Anemia	☐	☐	
Epilepsy	☐	☐		High Cholesterol	☐	☐					

PAST HISTORY (Personal):

Have you had any of the following illnesses?

	YES	NO		YES	NO
Rheumatic Fever	☐	☐	Cancer/Tumor	☐	☐
Angina Pectoris	☐	☐	Frequent Kidney	☐	☐
Heart Attack	☐	☐	or Bladder Infections	☐	☐
Other Heart Disease	☐	☐	Thyroid Disease	☐	☐
High Blood Pressure	☐	☐	Gallbladder Disease	☐	☐
Anemia	☐	☐	Hepatitis	☐	☐
Kidney Disease	☐	☐	Colitis	☐	☐
Gout	☐	☐	Arthritis	☐	☐
Hay Fever	☐	☐	Migraine Headache	☐	☐
Asthma	☐	☐	Osteoporosis	☐	☐
Frequent Bronchial			Radiation Therapy	☐	☐
or Lung Infections	☐	☐	Chemotherapy	☐	☐
Emphysema	☐	☐	Depression	☐	☐
Diabetes	☐	☐	Anxiety	☐	☐
Kidney Stones	☐	☐	Stroke	☐	☐
High Cholesterol	☐	☐	Other _____		

Surgeries: List and indicate approximate year.

_____

_____

_____

_____

Hospitalizations (other than surgeries): List reasons and approximate dates.

_____

_____

_____

_____

Serious Injuries (Other than the above): List and give approximate dates.

_____

_____

_____

_____

Diagnostic Tests: List and give approximate dates.
(Ex: X-ray, EKG's, ultrasounds, etc.)

_____

_____

_____

_____

Immunizations: Please give dates.

Pneumonia Shot _____ Flu _____

Tetanus _____

Are you allergic to any medications? Yes ☐ No ☐

If yes, please list the name(s) and the reaction(s) you had to them: _____

_____

_____

Are you allergic to any foods? Yes ☐ No ☐

If yes, please list: _____

PERSONAL HABITS:

1. Do you smoke? Yes ____ No _____ Never _____
   ☐ Cigarettes: Number per day _____ ☐ Pipe ☐ Cigars
   How long have you been smoking? _____ Years
   If quit, how long ago? _____
   Do you chew tobacco? Yes ☐ No ☐

2. Do you drink alcoholic beverages? Yes ☐ No ☐
   ☐ Hard Liquor 1-3 oz. per day ☐ Over 3 oz. per day ☐
   ☐ Beer 1 can per day ☐ 2 cans ☐ 3 or more ☐
   ☐ Wine 1 glass per day ☐ 2 glasses ☐ 3 or more ☐

3. Do you drink caffeinated beverages?
   Yes ☐ No ☐ 3 or more cups ☐
   Decaffeinated Coffee ☐ Regular Coffee ☐ Soda ☐

4. Do you drink soft drinks? Yes ☐ No ☐
   Regular ☐ Diet ☐
   How many/day _____

5. Do you use recreational drugs (such as pot, cocaine, etc.)?
   Yes ☐ No ☐

6. Do you have difficulty sleeping?
   Never ☐ Often ☐ Sometimes ☐

7. Hours usually slept: _____ hrs.

8. Do you awaken very early in the morning without apparent cause and find it difficult to fall asleep again?
   Frequently ☐ Occasionally ☐ Rarely ☐

9. Do you wear your seatbelt? Yes ☐ No ☐

MEDICATIONS: (Includes over-the-counter drugs)

Check which of the following if any, you are regularly taking:

☐ Antacids
☐ Asthma or wheezing medicine
☐ Aspirin, Bufferin, Anacin Tylenol, or similar products
☐ Birth Control pills
☐ Blood pressure pills
☐ Cortisone, Prednisone
☐ Cough Medicine
☐ Digitalis or heart medicine
☐ Estrogen
☐ Hormones
☐ Insulin or diabetes pills
☐ Iron or poor-blood medications
☐ Laxatives
☐ Sleeping pills or tranquilizers
☐ Thyroid medicine
☐ Stomach or digestive medicine
☐ Weight-reducing pills
☐ Blood-thinner or Coumadin
☐ Dilantin
☐ Water pills, diuretics
☐ Antibiotics
☐ Nerve/relaxation pills
☐ Vitamins
☐ Herbs
☐ Other Drugs (List Below)

_____

_____

_____

	YES	NO
Are you frequently confined to bed by illness?	☐	☐
Have you had difficulty obtaining health/life insurance for physical reasons?	☐	☐
Does pain or discomfort awaken you at night?	☐	☐
Do you wear yourself out worrying about your health?		☐
Do you think you may have a tumor or cancer?	☐	☐
Do you think you may have trouble with your heart?	☐	☐
Do you have frequent fevers/chills?	☐	☐
Has your weight changed in the last year?	☐	☐
up _____ down _____ amt. _____		
Are you subject to recurrent infections?	☐	☐
Are you frequently ill?	☐	☐

When was your last physical examination? Date _____

Doctor _____ Address _____

SOCIAL HISTORY:

	YES	NO
Have you recently lived or traveled outside THIS REGION?	☐	☐

Where _____

Circle last year of school attended:

Grade School 1 2 3 4 5 6 7 8

High School 9 10 11 12

College 1 2 3 4

Post Graduate

Did you serve in the military?	☐	☐
Were you rejected from the Military Service?	☐	☐

If yes, why? _____

Have you ever been rejected for life or health insurance or had to pay an extra premium?	☐	☐
Do you eat less than three meals a day?	☐	☐
Do you have special food customs or restrictions?	☐	☐
Have you ever been treated for a drinking problem?	☐	☐
Do you exercise less than three times a week?	☐	☐
Do you not have a hobby or hobbies?	☐	☐
Are you active in political, community, or church activities?	☐	☐
Have you taken a vacation in the last 12 months?	☐	☐

Please identify your hobbies and current exercise program:

_____

_____

MARITAL/FAMILY/SIGNIFICANT OTHERS:

	YES	NO
Have you been married more than one time?	☐	☐
Has there been a recent change in your marital status/relationship?	☐	☐
Does your age and your spouse's age differ by more than 10 years?	☐	☐
Are there any problems with your married life?	☐	☐

Who is the person you count on the most: _____

Do you have any sex problems?	☐	☐

Do you consider yourself: ☐heterosexual ☐homosexual ☐bisexual

If a widow or widower, have you had difficulty adjusting to your spouse's death?	☐	☐
Do you have any serious problems with your children?	☐	☐
Is your present home life causing unhappiness?	☐	☐
Have there been any deaths in your family or among close friends in the past year or two?	☐	☐
Does anyone in your family have a serious illness or disability?	☐	☐
Does anyone in your family have a drug or alcohol problem?	☐	☐

If so, who? _____

OCCUPATIONAL:

	YES	NO
Are you currently employed?	☐	☐

Where? _____

Hours/week _____ Shift _____

Are you dissatisfied with your present type of work?	☐	☐
Does your work involve unusual work, exposure to dust, noise, radioactivity, etc.?	☐	☐
Do you have more than one job?	☐	☐
Do you work more than 40 hours a week?	☐	☐
Do you get along poorly with your fellow employees and/or your supervisors?	☐	☐
Are you unable to perform any work because of disability?	☐	☐

What is your disability? _____

Have you missed more than 10 days of work in the past 6 months?	☐	☐
Are you retired? If yes, how long: _____	☐	☐
If retired, have you had difficulty adjusting to retirement?	☐	☐
If a housewife, do you find your housework difficult?	☐	☐
If a housewife, are you unhappy with your housework?	☐	☐

A.	YES	NO
Is your skin very sensitive or tender?	☐	☐
Do cuts in your skin stay open a long time?	☐	☐
Does your face often get badly flushed?	☐	☐
Do you sweat a great deal even in cold weather?	☐	☐
Are you bothered by severe itching?	☐	☐
Does your skin often break out in a rash?	☐	☐
Do you have boils frequently?	☐	☐
Has there been a change in the color, temperature or texture of your skin?	☐	☐
Has there been a change in texture of your hair or nails?	☐	☐

B.

Do you have severe headaches?	☐	☐
Does pressure or pain in the head often make life miserable?	☐	☐
Do you have hot or cold spells?	☐	☐
Do you have frequent spells of dizziness?	☐	☐
Do you frequently feel faint?	☐	☐
Have you ever fainted or passed out?	☐	☐
Do you have numbness or tingling in any part of your body?	☐	☐
Has any part of your body ever been paralyzed?	☐	☐
Were you ever knocked unconscious?	☐	☐
Have you ever had a fit or convulsion (epilepsy)?	☐	☐

C.	YES	NO
Do you need glasses/contacts to read?	☐	☐
Do you need glasses/contacts to see things at a distance?	☐	☐
Has your eyesight blacked out completely?	☐	☐
Do your eyes continually blink or water?	☐	☐
Do you often have pain in your eyes?	☐	☐
Are your eyes often red or inflamed?	☐	☐
Do you have blurring of vision?	☐	☐
Do you have double vision?	☐	☐
Do you have glaucoma?	☐	☐
Do you use eye drops?	☐	☐
Do you have cataracts?	☐	☐
Are your eyes excessively dry?	☐	☐
When was your last eye exam? _____		

D.		
Are you hard of hearing?	☐	☐
Have you ever had a running ear?	☐	☐
Do you have constant noises in your ears?	☐	☐
Do you suffer from a constantly running nose?	☐	☐
Is your mouth excessively dry?	☐	☐
Do you have chronic trouble with your nose or throat?	☐	☐
Have you had frequent nose bleeds?	☐	☐
When you catch a cold, do you have to go to bed?	☐	☐
Are you often troubled with spells of sneezing?	☐	☐
Is your nose continually stuffed up?	☐	☐
Do you often catch severe colds?	☐	☐
Do you have to clear your throat frequently?	☐	☐
Do you frequently feel a choking lump in your throat?	☐	☐
Do you frequently have sore throats?	☐	☐
Do you have persistent hoarseness?	☐	☐

E.		
Do you frequently suffer from heavy chest colds?	☐	☐
Number in past 12 months _____		
Have you coughed up blood?	☐	☐
Do you have sputum or phlegm between colds?	☐	☐
Do you have severe soaking sweats at night?	☐	☐
Have you ever had tuberculosis?	☐	☐
Results: positive _____ negative _____		
Have you been around anyone who had tuberculosis?	☐	☐
When _____		
Have you ever had pneumonia?	☐	☐
Age _____		
Have you ever had any wheezing or whistling in your chest?	☐	☐
Have you ever had an asthma attack?	☐	☐
Do you have a chronic chest condition?	☐	☐
Have you ever worked in a dusty atmosphere or in close contact with rocks (silica) dust?	☐	☐

F.	YES	NO
Has a doctor ever said your blood pressure was too high?	☐	☐
Has a doctor ever said your blood pressure was too low?	☐	☐
Do you have pains in your heart or chest?	☐	☐
Has a doctor ever said you had heart trouble?	☐	☐
Are you bothered by thumping of the heart?	☐	☐
Does your heart race?	☐	☐
Does your heart miss a beat or beat irregularly?	☐	☐
Has a doctor ever said you had a heart murmur?	☐	☐
Do you have difficulty breathing?	☐	☐
Do you get out of breath long before anyone else?	☐	☐
Do you sometimes get out of breath just sitting still?	☐	☐
Do your ankles swell?	☐	☐
Must you sleep propped up, having difficulty breathing lying flat?	☐	☐
Do you wake up at night short of breath?	☐	☐
Do you wake up at night with chest pain?	☐	☐
Do you have frequent leg cramps?	☐	☐
a. When you walk?	☐	☐
b. When you are resting (i.e. at night)?	☐	☐
Have you ever had inflammation in your veins (phlebitis)?	☐	☐
Have you had a chest x-ray or cat scan?	☐	☐
Year _____ Where _____		
Have you had an electrocardiogram?	☐	☐
Year _____ Where _____		
Have you had a stress test/heart study?	☐	☐
Year _____ Where _____		
Do your fingers or toes ever get cold, become numb, or get very white or blue?	☐	☐

G.		
Have you lost more than half of your teeth?	☐	☐
Are you troubled with bleeding gums?	☐	☐
Is your tongue usually badly coated?	☐	☐
Do you gulp for food in a hurry?	☐	☐
Do you have frequent indigestion?	☐	☐
Do you feel acid fluid/food come back up in your throat?	☐	☐
Is it worse at bedtime?	☐	☐
Do you usually feel bloated after eating?	☐	☐
Do you belch a lot after eating?	☐	☐
Are you often sick to your stomach?	☐	☐
Does severe pain in your stomach often double you up?	☐	☐
Has a doctor ever said you had an ulcer?	☐	☐
When _____		
Confirmed by x-ray?	☐	☐
Do you have normal bowel movements?	☐	☐

G. - Continued	YES	NO
Do you constantly suffer from constipation?	☐	☐
Do you have diarrhea?	☐	☐
Number of stools per day _____		
Have you ever had bloody diarrhea?	☐	☐
Do you have fresh blood in your stool?	☐	☐
Have your bowel habits changed recently?	☐	☐
Were you ever troubled with intestinal worms?	☐	☐
Have you ever had jaundice (yellow eyes and skin)?	☐	☐
Have you ever had rectal hemorrhoids?	☐	☐
Have you ever had severe liver or gall bladder trouble?	☐	☐
Have you ever had:		
a. difficulty swallowing?	☐	☐
b. Hiatal hernia (portion of stomach in chest cavity)?	☐	☐
c. vomiting of blood?	☐	☐
d. black or tarry stools?	☐	☐
Have you ever had x-rays of your:		
a. stomach (upper g.i.) Year _____	☐	☐
b. colon (lower g.i.) Year _____	☐	☐
c. gall bladder Year _____	☐	☐
d. abdomen Year_____	☐	☐

H.

Do you usually have to get up at night to urinate?	☐	☐
Number of times _____		
Is this new in the last year?	☐	☐
During the day do you have to urinate frequently?	☐	☐
Do you sometimes lose control of your bladder?	☐	☐
Has a doctor ever said that you had kidney or bladder diseases?	☐	☐
Have you had excessively dark (i.e. brown) urine?	☐	☐
Have you ever had protein (albumen) in your urine?	☐	☐
Were you ever a bed wetter?	☐	☐
Have you had special studies on your kidneys or urinary tract?	☐	☐
Year _____ Where _____		

FEMALES ONLY: MALES GO TO J

I.

Have you ever been pregnant?	☐	☐
Number of live births _____		
Weight of largest baby _____ lbs.		
Complications:	☐	☐
High blood pressure	☐	☐
Hemorrhage	☐	☐
Gestational diabetes	☐	☐
Number of miscarriages/abortions_____		
Do you still menstruate?	☐	☐
If no, at what age did you stop? _____		

I. - Continued	YES	NO
If yes, at what age did you start? _____		
a. Date of last period? _____		
b. Number of days from first day of period to first day of next period? _____		
c. Number of days of flow? _____		
d. Are your periods heavy?	☐	☐
e. Do you spot/bleed between periods?	☐	☐
f. Are your menstrual periods usually painful?	☐	☐
g. Are you weak or sick with your periods?	☐	☐
Date of last PAP smear? _____		
Date of last mammogram? _____		
Have you ever had any trouble with your breasts?	☐	☐
Do you examine your breasts once per month?	☐	☐
Have you ever had treatment for your genital organs?	☐	☐
Do you take calcium supplement for your bones?	☐	☐

MALES ONLY: FEMALES GO TO K

J.

Do you have trouble starting your urine stream?	☐	☐
Has the size or force of your urine stream changed?	☐	☐
Have you ever had an enlarged testicle or scrotum?	☐	☐
Do you have or have you ever had any problems with your sex or domestic life?	☐	☐
Have you ever had treatment for your genital organs?	☐	☐
Do you examine your testicles once per month?	☐	☐

K.

Do you have pains in your joints?	☐	☐
Do your joints swell?	☐	☐
Are you stiff in the morning?	☐	☐
How long _____		
Do you have severe pains in the arms, legs, or feet?	☐	☐
Are you crippled with arthritis?	☐	☐
Do pains in the back make it hard for you to keep up with your work?	☐	☐
Are you troubled with a serious body disability or deformity?	☐	☐
Has any joint been red or hot?	☐	☐
Are your muscles painful?	☐	☐
Are your muscles weak?	☐	☐

L.

Are you colder than people around you?	☐	☐
Are you warmer than people around you?	☐	☐
Do you sleep excessively?	☐	☐
Do you drink large quantities of water/fluids?	☐	☐
Has anyone ever found sugar in your urine or elevated blood sugar?	☐	☐
Do you crave salt?	☐	☐

L. - Continued	YES	NO
Have you ever taken thyroid medication?	☐	☐
When? _____		
Have you ever taken cortisone or prednisone?	☐	☐
By mouth	☐	☐
By injection	☐	☐
When? _____		
Why? _____		
Has your sexual desire changed?	☐	☐

M.

Do you bleed easily?	☐	☐
Have you ever received a blood transfusion?	☐	☐
When? _____		
Why? _____		
Have you ever been told you have too little blood (anemia)?	☐	☐

N.

Do you have trouble relaxing?	☐	☐
Are you always exhausted?	☐	☐
Is everything an effort?	☐	☐
Do you wake up tired and exhausted?	☐	☐
Does every little effort wear you out?	☐	☐
Are you nervous?	☐	☐
Do you suffer from nervous exhaustion?	☐	☐
Do you have difficulty falling asleep?	☐	☐
Do you frequently awaken earlier than usual and find it hard to get back to sleep?	☐	☐
Do you have frequent nightmares?	☐	☐
Are you frequently too tired for sex?	☐	☐
Are you as tired when you wake up as when you went to bed?	☐	☐
Do you sweat or tremble a lot during examinations or questioning?	☐	☐
Do you get nervous and shaky when approached by a superior?	☐	☐
Does your work fall to pieces when the boss or a superior is watching you?	☐	☐
Does your thinking get completely mixed up when you have to do things quickly?	☐	☐
Must you do things very slowly in order to do them without mistakes?	☐	☐
Do you get orders and directions wrong?	☐	☐
Do strange people or places make you afraid?	☐	☐
Are you afraid to be alone?	☐	☐
Do you have trouble making decisions?	☐	☐

O.

Do you feel alone and sad at a party?	☐	☐
Do you feel unhappy?	☐	☐
Do you cry often or feel like it frequently?	☐	☐
Are you often miserable and blue?	☐	☐

O. - Continued	YES	NO
Does life look entirely hopeless?	☐	☐
Do you often wish you were dead and away from it all?	☐	☐
Have you thought of ending your life?	☐	☐
Do you feel useful and needed?	☐	☐
Are you happy with yourself?	☐	☐
Does worrying continually get you down?	☐	☐
Do you feel depressed a lot of the time?	☐	☐

P.

Do you often worry about your financial situation?	☐	☐
When you were growing up, did your parents have a hard time making ends meet?	☐	☐
Do you often have a hard time finding someone to watch your children when you're busy or just want some leisure time to yourself?	☐	☐
Do you generally feel that things in your life are on top of you rather than you being on top of things?	☐	☐
Do you feel that you do more for others than they do for you?	☐	☐
Do you often feel there is no one to turn to when you want to talk over problems or share concerns?	☐	☐
Do you or your children feel unsafe or unhappy living in your present residence?	☐	☐
Does worrying run in your family?	☐	☐
Does every little thing get on your nerves and wear you out?	☐	☐
Does nervousness run in your family?	☐	☐
Did you ever have a nervous breakdown?	☐	☐
Did anyone in your family ever have a nervous breakdown?	☐	☐
Were you ever a patient in a mental hospital?	☐	☐
Was anyone in your family ever a patient in a mental hospital?	☐	☐

Q.

Are you in control?	☐	☐
Are you extremely shy or sensitive?	☐	☐
Do you come from a shy or sensitive family?	☐	☐
Are your feelings easily hurt?	☐	☐
Does criticism upset you?	☐	☐
Are you considered to be a touchy person?	☐	☐
Do people usually misunderstand you?	☐	☐
Do you have to be on guard even with your friends?	☐	☐
Do you always do things on sudden impulse?	☐	☐
Are you easily upset or irritated?	☐	☐
Do you go to pieces if you don't constantly control yourself?	☐	☐
Do little annoyances get on your nerves and make you angry?	☐	☐
Does it make you angry to have anyone tell you what to do?	☐	☐

Q. - Continued	YES	NO
Do people often annoy and irritate you?	☐	☐
Do you flare up in anger if you can't have what you want right away?	☐	☐
Do you often get into a violent rage?	☐	☐
Do you think you will ever be well again?	☐	☐
R.		
Do you often shake or tremble?	☐	☐
Are you constantly keyed up and jittery?	☐	☐
Do sudden noises make you jump or shake badly?	☐	☐
Do you tremble or feel weak whenever someone shouts at you?	☐	☐
Do you become scared at sudden movements or noises at night?	☐	☐
Are you awakened out of your sleep by frightening dreams?	☐	☐
Do frightening thoughts keep coming back in your mind?	☐	☐
Do you often become suddenly scared for no reason?	☐	☐
Do you often break out in a cold sweat?	☐	☐

	YES	NO
Do you have or have you had a serious illness not already listed? If so, what? (Heart, lungs, kidney, chest, bowel, liver, etc.) List on other side.	☐	☐
Do you have any additional information which you think might be helpful in your care? List on other side.	☐	☐
Is there anything you would especially like to discuss with me? Please elaborate on next page.	☐	☐

OTHER DOCTORS: Please list all other doctors **and** their phone numbers.

_____

_____

_____

_____

_____

_____

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_____

_____

ADDITIONAL COMMENTS:

_____

_____

_____

_____

_____

**Please list all medications and vitamins you are currently taking. (prescription and over the counter)

Name Strength Frequency Medication Taken (ex: once a day, twice a day)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

(If more room is needed, please continue onto the back of this form.)

PATIENT INFORMATION

Confidential Record: Information contained here will not be released without your permission. Please complete **all** information to the best of your knowledge. If you should have difficulty, or do not understand a question, please ask the receptionist for assistance.

Last Name	First	Middle	Birth Date	Age

Address	City	State	Zip	Home Phone	Work Phone

If patient is a minor, parent or guardian's name	E-Mail Address	Is your problem related to work or an accident? *(If Yes, complete reverse side of this form.)* ❑ Yes ❑ No

Employer / Address / Phone Occupation *(If patient is a minor, need parent or guardian's info here)*	Patient's Social Security #	Sex: Male ❑ Female ❑	Marital Status ❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed

Do You Have Insurance? ❑ Yes ❑ No	If not, how do you intend to pay? ❑ Cash ❑ Check ❑ Credit Card	In case of emergency please contact: Relationship: Phone #

Insurance Company Insurance ID # Group ID #	Medicare # Medicaid # Name of PAAS Provider:

Subscribers Full Name & Address (If different from above) Relationship to patient?	Subscriber's: Date of Birth - Social Security Number -

Does your insurance plan require that you have a referral for this visit? ❑ Yes ❑ No
If Yes, does this office have the referral? ❑ Yes ❑ No **It is your responsibility to obtain a referral if one is needed. IF YOUR INSURANCE REQUIRES A REFERRAL AND YOU ARE SEEN WITHOUT A REFERRAL ON FILE, YOU ARE RESPONSIBLE FOR PAYMENT OF ALL FEES.**

Name of your Primary Care (Family) Doctor: Name and location of your preferred Pharmacy:	Who may we thank for referring you? ❑ Physician, Name: ❑ Friend, Name: ❑ Yellow Pages ❑ Other, Specify:	I have received a copy of the practice's Payment Policy. ❑ Yes ❑ No

.....CONSENT FOR RELEASE OF INFORMATION.....

I, the undersigned, understand that Diabetes, Endocrinology & Lipidology Center, Inc. (DELC) is in need of information related to my medical history and treatment. I authorize other health care providers and entities to provide DELC with the information described in the accompanying letter of request.

_____ _____ _____
Signature of Patient *Power of Attorney or If Under18, Guardian (state relationship)* **Date**

.....ASSIGNMENT OF BENEFITS.....

I authorize my insurance benefits to be paid directly to Diabetes, Endocrinology & Lipidology Center, Inc. realizing that I am responsible for non-covered services.

_____ _____ _____
Signature of Patient *Power of Attorney or If Under18, Guardian (state relationship)* **Date**

ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY POLICIES AND PRACTICES

** You may refuse to sign this acknowledgement **

I, [Print Name]_____, have received a copy of Diabetes, Endocrinology & Lipidology Center, Inc.'s Notice of Privacy Policies and Practices.

I **[ ] DO, [ ] DO NOT** give this office authorization to contact me directly at work or leave messages on my answering machine regarding my care.

Please list any persons you would like to authorize to have access to your billing, appointment or health information such as your spouse, caregiver or family member. *If known, provide the last 4 digits of their Social Security Number and/or Date of Birth so that we may identify the individual over the phone.*

Name	Contact Phone Number	Relationship	Last 4 digits of Social Sec #	Date of Birth

Signature: _____

Date: _____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign.
- ☐ Communications barriers prohibited obtaining the acknowledgement.
- ☐ An emergency situation prevented us from obtaining acknowledgement.
- ☐ Other (specify)

_____

_____

_____

Staff Signature: _____

Diabetes, Endocrinology & Lipidology Center, Inc.

Information, Policy Notice & Agreement

We are committed to providing you with quality and affordable health care and we take a "no surprises" approach to the delivery of services.

1. Insurance - At every check-in, please sign in and present your driver's license and insurance card to the receptionist. State if you have had a change of name, address, phone numbers or **insurance**. Insurance denials or billing errors resulting from inaccurate or out-dated (patient supplied) information will result in the immediate transfer of the account balance to the patient's responsibility. Payment, in full, at the time of service is required:

- If you are a self pay patient,
- If you are insured by a plan which with which we do not participate, or
- If you are insured by a plan we do participate with; however, you do not present a current insurance card.

We cannot know everyone's insurance coverage, benefits, referral/pre-authorization/pre-certification requirements or even if the practice participates with a particular plan. Your health insurance is a contract between you and your insurance plan(s). Knowing this information is your responsibility; not ours. Contact your insurance company with questions. When asked a question, we may give an opinion; however, we assume no responsibility. It is the patient's task to obtain all necessary documentation (referral, authorization, etc.). If, for any reason, you receive services from this office for which your insurance payer denies payment you will be personally responsible for payment of the full fee. These denials include, but are not limited to, non-covered services, failure to pre-authorize service, termination of coverage or exceed benefit limitations. If your insurance company does not pay your claim within 45 days, the balance will be billed to you.

2. Co-payments, Deductibles and Balances - You agree to pay all insurance co-payments, deductibles and/or balances at the time of service.

3. Claim Submission - We utilize a billing company, Medical Management Solutions, Inc. (MMS), to submit your claims. MMS will assist you in any reasonable way to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Be aware that any balance, after insurance, is your responsibility.

4. Delinquent Accounts - A late payment penalty is applied to accounts over 28 days past due. Partial payments will not be accepted unless otherwise negotiated. Be aware that after 60 days if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If the account is assigned to a 'collection agency' you agree to pay all collection agency fees, court costs, and attorney fees. You understand and agree that all accounts with a balance over 30 days will be assessed a 1.5 percent late charge per month (18% APR) on the unpaid monthly balance.

5. Broken Appointments - Failure to cancel an appointment by providing at least 48 hours advance notice will result in a broken appointment fee of up to $50. You are personally responsible for payment of this fee regardless of your insurance. Patients who miss two (2) appointments are discharged from the practice.

6. Returned Check Fee - A fee of up to $50 is charged for each check returned for any reason.

AGREEMENT

My signature below confirms that I understand the information and agree to all conditions and terms explained in this document. In consideration for medical services rendered, I understand and agree that I am financially responsible for the payment all charges within 30 days of notice; regardless of third-party involvement. I agree that a copy or facsimile of this consent, assignment and signature is as valid as the original.

Consent To Receive Phone Calls and Messages: You authorize us, Diabetes, Endocrinology & Lipidology Center, Inc. (DELC), our successors or assigns, to call you or send a text message to you at any number you provide or at any number at which we reasonably believe we can contact you, including calls to mobile, cellular, or similar devices, and including calls using automatic telephone dialing systems and/or prerecorded messages, for any lawful purpose, including but not limited to: (1) suspected fraud or identity theft; (2) obtaining information necessary or desirable; (3) you account transactions or servicing; and (4) collecting on your Account. Numbers you provide include numbers you give us and/or numbers from which you call us, our successors or assigns. You agree to pay any fees(s) or charges(s) that you may incur for incoming calls from us, and/or outgoing calls to us, to or from any such number, without reimbursement from us.

_____ _____

Signature of Patient/Power of Attorney or If Under18, Guarantor/Guardian (state relationship) Date