Endocrine and Diabetes Associates, LLC Drs. Petrick, Liu, Chanduvi, Shetty, Gupta, Almecci and Rogstad

PATIENT INFORMATION	Patient Name:	SSN:	DOB: / /	Sex:	Marital Status:

Race:
- ❑ American Indian or Alaska Native
- ❑ Asian
- ❑ Black or African American
- ❑ White
- ❑ Native Hawaiian
- ❑ Other Pacific Islander
- ❑ Other
- ❑ Prefer not to specify

Ethnicity:
- ❑ Hispanic
- ❑ Non-Hispanic

Preferred Language:

Street Address	Home #	Work# Ext:
City, State, Zip	Fax#	Cell#
Employer		

Primary Care Physician	Referring Physician	Personal email:

PHARMACY NAME & PHONE NUMBER (LOCAL and/or MAIL ORDER)

FINANCIALLY RESPONSIBLE PARTY (IF MINOR OR DEPENDENT)

Guarantors Last Name:	First Name MI	Work#
Street Address	City, State, Zip	Home#
Employer	Employer Address	

PRIMARY INSURANCE INFORMATION

Insurance Company	ID#		Group#
Policy Holder's Name	Policy Holder's DOB		Policy Holder's SSN
Policy Holder's Employer	Patient Relationship to Policy Holder	Insurance Effective Dates	Visit CoPay

SECONDARY INSURANCE INFORMATION

Insurance Company	ID#		Group#
Policy Holder's Name	Policy Holder's DOB		Policy Holder's SSN
Policy Holder's Employer	Patient Relationship to Policy Holder	Insurance Effective Dates	Visit CoPay

EMERGENCY CONTACT

Name	Phone	Relationship

1. FINANCIAL RESPONSIBILITY

I certify that the information I have provided regarding my insurance coverage is correct and authorize Endocrine & Diabetes Associates to verify the insurance coverage and benefits allowed in accordance with my insurance plan's policies.

I authorize that payment be made directly to Endocrine & Diabetes Associates for all medical benefits which are payable under the terms of my insurance policy for the services provided. I agree to pay copayments, coinsurance, or deductible, are required by my insurance plan. I understand that I am responsible for knowing the terms and regulations of my insurance plan, and I agree to accept full responsibility for payment if my insurance plan is invalid. I will be responsible for all lab charges denied for insurance payment if I have not notified Endocrine and Diabetes Associates of lab billing problems within 10 days of receiving a bill from the laboratory.

I will be charged a $75 fee for same day cancellation or missed appointments without 24 hours notice.

I will be assessed a $40 fee for any check returned by my bank. An account unpaid after repeated notification will be forwarded to Transworld Systems for collection. A collection fee of 40% and a processing fee of $9.50 will be assessed.

2. RELEASE OF MEDICAL INFORMATION

I hereby authorize Endocrine and Diabetes Associates to retrieve my prescription drug history. They may submit a claim to my insurance company for medical services provided to me or my dependant, to provide a copy of this release and a copy of medical records related to such services if requested by the payer, and to release medical information to my primary care or consulting physicians to assist with continuity of my health care. This release will remain in effect until I cancel this release in writing.

3. NON-COVERED SERVICES

I agreed to pay for medical services provided to me or my dependant which are not covered by the benefits in my insurance plan.

I Agree To The Above Stated Responsibility and Consent:

______________________________ **Date:** ______________________________

Signature of Patient or Legal Guardian

Updated 2.27.2020

Endocrine and Diabetes Associates, LLC

Patricia A Petrick, MD FACP
Linda Liu, MD FACP
Beatriz H. Chanduvi, MD FACE
Archana Shetty, MD
Anurag Gupta, MD
Yemul Almecci, MD
Amy Rogstad, MD

6430 Rockledge Drive, Suite 300
Bethesda, Maryland 20817
Phone 301-468-1451
Fax 301-468-3580

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

PATIENT NAME ______________________________

DATE OF BIRTH: ______________________________

SOC SEC or ID # ______________________________

I hereby authorize ______________________________
(name of your doctor or facility)

FAX# ______________________

____
(address)
____

to furnish information from my medical records, to include history/exam, laboratory and/or radiology reports, and any information pertinent to my **appointment** provider at Endocrine and Diabetes Associates, LLC.

This authorization shall expire without my express revocation one year from the date written below. I understand that I have the right to withdraw this authorization at any time, except to the extent that action has been taken on this authorization

______________________________ ______________
Signature of Patient or Guardian **Date**

HEALTH HISTORY

Confidential

Patient Name ______________________ Today's Date ____________

Age ________ Birth Date ______________ Date of Last Physical Examination ______________

What is your reason for visit? ______________________

SYMPTOMS - Check (✓) symptoms you currently have or have had in the past year.

GENERAL

- ❑ Chills
- ❑ Depression
- ❑ Dizziness
- ❑ Fainting
- ❑ Fatigue
- ❑ Fever
- ❑ Forgetfulness
- ❑ Headache
- ❑ High/low blood sugar
- ❑ Loss of sleep / poor sleep
- ❑ Nervousness
- ❑ Numbness
- ❑ Sensitivity to cold or heat
- ❑ Sweats
- ❑ Tremors
- ❑ Weight loss / gain

GENITO-URINARY

- ❑ Blood in urine
- ❑ Frequent urination
- ❑ Lack of bladder control
- ❑ Painful Urination
- ❑ Urination at night

GASTROINTESTINAL

- ❑ Appetite poor
- ❑ Bloating
- ❑ Bowel changes
- ❑ Constipation
- ❑ Diarrhea
- ❑ Excessive hunger
- ❑ Excessive thirst
- ❑ Gas
- ❑ Indigestion / Reflux
- ❑ Nausea
- ❑ Rectal bleeding
- ❑ Stomach pain
- ❑ Vomiting

CARDIOVASCULAR

- ❑ Chest pain
- ❑ High blood pressure
- ❑ Irregular heart beat
- ❑ Low blood pressure
- ❑ Rapid heart beat
- ❑ Swelling of ankles
- ❑ Varicose veins

EYE, EAR, NOSE, THROAT

- ❑ Blurred vision
- ❑ Difficulty swallowing
- ❑ Double vision
- ❑ Earache
- ❑ Hoarseness
- ❑ Loss of hearing
- ❑ Persistent cough

SKIN

- ❑ Hives
- ❑ Itching
- ❑ Rash
- ❑ Sore that won't heal

MEN only

- ❑ Breast enlargement
- ❑ Breast lump
- ❑ Erection difficulties
- ❑ Lump in testicles
- ❑ Penis discharge
- ❑ Poor libido
- ❑ Sore on penis
- ❑ Other ____________

WOMEN only

- ❑ Abnormal Pap Smear
- ❑ Bleeding between periods
- ❑ Breast lump or tenderness
- ❑ Hot Flashes
- ❑ Painful intercourse
- ❑ Poor libido
- ❑ Nipple Discharge
- ❑ Vaginal Discharge
- ❑ Other

Date of Last Menstrual Period ____________

Date of Last PAP Smear ____________

When was your last mammogram? ____________

Are you Pregnant? ____________

CONDITIONS - Check (✓) conditions you have or have had in the past,

- ❑ AIDS / HIV Positive
- ❑ Alcoholism
- ❑ Anemia
- ❑ Arthritis
- ❑ Asthma
- ❑ Bleeding Disorders
- ❑ Breast Lump
- ❑ Bronchitis
- ❑ Cancer
- ❑ Cataracts
- ❑ Chemical Dependency
- ❑ Chicken Pox
- ❑ **Diabetes**
- ❑ Eating disorder
- ❑ Emphysema
- ❑ **Glaucoma**
- ❑ **Goiter**
- ❑ Gout
- ❑ Heart Disease
- ❑ Hepatitis
- ❑ **High Cholesterol/High Lipids**
- ❑ **Kidney Disease / Stones**
- ❑ Liver Disease/ Hepatitis
- ❑ Migraine Headaches
- ❑ Miscarriage
- ❑ Pacemaker
- ❑ Pneumonia
- ❑ Polio
- ❑ Prostate Problem
- ❑ Psychiatric Care
- ❑ Seizure
- ❑ Sexually transmitted disease
- ❑ Stroke
- ❑ Suicide attempts
- ❑ **Thyroid Problems**
- ❑ Tuberculosis
- ❑ Ulcers
- ❑ Vaginal Infections

MEDICATIONS List medications you are currently taking.

____

____

____

____

____

Pharmacy Name ______________________

Phone number ______________________

ALLERGIES To medications or substances.

____

____

____

____

____

❑ None

FAMILY HISTORY Fill in information about your immediate family.

Relation	Current Age	Year Of Birth	State of Health	Age at Death	Cause of Death	Check if any of you blood relatives had any of the following: Disease	Relationship to You
Father						❑ Adrenal Disorder	
Mother						❑ Calcium Disorders / Kidney Stones	
Brothers						❑ Cancer	
						❑ Diabetes	
						❑ Heart Disease, Strokes	
						❑ High Blood Pressure	
Sisters						❑ Osteoporosis	
						❑ Pituitary Disorders	
						❑ Thyroid Disorders	
						❑ Cholesterol / Lipids	
Children						❑ Psychiatric Disorders	
total # of children ________						❑ Other	

HOSPITALIZATIONS / SURGICAL PROCEDURES

Year	Facility	Procedures, Reason and Outcome

PREGNANCY HISTORY

Year of birth	Sex of birth	Complications if any

SERIOUS ILLNESSES/INJURIES	DATE	OUTCOME

HEALTH HABITS For each substance below.

Describe how much you use below as: Never, Prior, Current

Substance	Use
❑ Caffeine	
❑ Tobacco	
❑ Recreational Drugs	
❑ Alcohol	

OCCUPATION:

To the best of my knowledge the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

____
Signature of Patient, Parent, Guardian or Personal Representative

____
Date

____
Print Name of Patient, Parent, Guardian or Personal Representative

____
Relationship to Patient