Endocrine and Diabetes Care, P.C.

General Patient Information

Date: _______________

Last Name: _____________________________ First Name: _____________________________

Home Tel: _____________________________ Work Tel: _______________________________

Cell Tel: _______________________________ Other Tel: _______________________________

SS#___________________________________

Sex (Circle One): Male Female E-Mail Address: __________________________

Address: ____

City: ___________________________________ State: ____________ Zip: ___________________

Date of Birth: ______/______/_______ SS#: ___________________________________

Occupation: _____________________________

Family Doctor: __________________________ Tel: ____________________________________

Emergency Contact: _______________________________________

Relationship to patient (Circle One): Spouse Parent/Guardian Other: __________________

Tel: _____________________________________

Insurance Information

Primary Insurance: ____

Insured Name: ____

Relationship to patient (Circle One): Self Spouse Parent/Guardian

Secondary Insurance: ____

Insured Name: ____

Relationship to patient (Circle One): Self Spouse Parent/Guardian

Medical History:

Medications

(Please list any medications you are currently taking)

Medication	Dosage	Notes

Past Medical History / Family History

(Please check any of the following conditions that apply to yourself or your family)

Family	Self		Family	Self	
		Diabetes			Heart Problems
		High Cholesterol			Previous Eye Disease
		Hypertension			Previous Eye Injury
		Cataracts			Previous Eye Surgery
		Glaucoma			Thyroid Disorder
If other, please specify:					

Allergies

(Please check any of the following allergies that apply to you)

	Aspirin		Seasonal
	Dust Mites		Sulfa Drugs
	Penicillin		**NO KNOWN ALLERGIES**
If other, please specify:			

Social History

(Please check if any of the following apply to you)

	alcohol use		illegal drug use
	tobacco use		**other:**

Surgical History

(Please list any surgeries you have underwent in the past)

Procedure	Year	Notes

******We must have the above information BEFORE you may see the doctor******

I assign directly to Manalapan Medical all medical insurance benefits. I understand that in the event the charges are applied to my insurance deductible or charges are not covered, or if my insurance is invalid. I am responsible for all balanced due.

I authorize any holder or medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services.

____

Signature of Patient, Parent, Guardian or Personal Representative

____

Please ***print*** name of Patient, Parent, Guardian or Personal Representative

_________________________________ _________________________________

Date Relationship to Patient

HIPAA PRIVACY

Acknowledgment of Receipt of Privacy Notice

By signing this acknowledgment of Receipt of Notice of Privacy Practices (the "Notice"), I acknowledge and agree that I have received, read and understand the Notice of the Notice Privacy Practices for review and to keep for my records on the date identified below.

I understand that the Location may use and disclose necessary personal health information (for example, my name, address, subscriber identification number, exam information and/or type of products provided) to another party to permit the Location to perform its administrative duties, provide me with medical care services and products, process my medical benefit claims and communicate with me regarding my care services provided by the Location (for example, mailings of exam reminders or information about services / products provided by the Location).

I can be assured that this location does not sell my personal health information of any kind to a third party for such party's own use. I authorize the Location to submit my medical benefit claims to my plan sponsor or health plan to receive reimbursement directly for the medical services and products that I have received from the Location.

______________________________________ ____________________

Patient Signature or Patient's legal Representative Date