THE ENDOCRINE CENTER

Board Certified, Endocrinology & Metabolism

Last Name _____ **First Name** _____ **MI** _____

Street _____ **City** _____ **State** _____ **Zip Code** _____

Preferred Contact Phone Number **HOME # (** _____ **)** _____ **CELL # (** _____ **)** _____

Alternate Contact Phone Number (_____ **)** _____

Email address: _____ **Birth Date** _____

Sex _____ **Social Security** _____ **Driver Lic. #** _____

Marital Status: (circle one) **Single / Married / Divorced / Widow** **Student Status:** **Full Time / Part-time / Non-student**

Preferred Language: _____ **Ethnicity:** (circle one) **HISPANIC or NON-HISPANIC**

Race: (circle one): **American Indian / Alaskan Native; Asian; African American; Caucasian; Pacific Islander; Other; Declined**

Primary Insurance: _____ **ID #:** _____

Secondary Insurance: _____ **ID #:** _____

Employer: _____

Street _____ **City** _____ **State** _____ **Zip Code** _____

Work Telephone # _____ **Ext: #** _____ **Fax #** _____

Referring Physician: _____ **Phone #** _____

Relationship to Insured: (circle one) **Self / Spouse / Child / Other**

If not <u>self</u>-please provide the information for responsible party.

Name: _____

Street: _____ **City** _____ **State** _____ **Zip Code** _____

Phone #: _____ **Work #:** _____ **Social Security #:** _____ **Date of Birth:** _____

……

Emergency Contact

Name: _____ **Relationship** _____ **Phone #** _____

Name: _____ **Relationship** _____ **Phone #** _____

Acknowledgment of Review of Privacy Practice

I have reviewed this office's Notice of Privacy Practices and HIPPA regulations, which explained how my medical information will be issued and disclosed.
I understand that I am entitled to receive a copy of this document.

……

I hereby assign, transfer and set over to The Endocrine Center, all my rights, title and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization I understand that I am financially responsible for all charges weather or not they are covered by insurance. I authorized
The Endocrine Center to treat as necessary for which I or my minor child is being seen. This includes, but is not necessarily limited to, injections, labs, diagnostic testing or any other treatment deemed proper care of my illness.

Signature of patient/ Guardian/ Representative: _____ Date: _____

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THE ENDOCRINE CENTER

Board Certified, Endocrinology & Metabolism

Procedure Policy

Patients must notify our office 24 hours prior to the appointment of a cancellation. Not showing for your appointment means there will be a charge as listed below. Being late to your appointment can also affect ability to be seen and we cannot guarantee your appointment will still be available if you arrive 15 minutes after your scheduled time.Please keep in mind these charges are your responsibility. We will not bill your insurance for these charges, nor will your insurance pay them. Also, payment for these fees is due prior to scheduling of another appointment, and continued instances of missing appointments may result in the office requiring that cost of the missed appointment be paid in lieu of a "no show" fee or that you find another physician. **INTIALS** _____

1st "no show"/cancel same day as appointment ------- No Charge
2nd "no show"/cancel same day as appointment -------- $25.00
3rd "no show"/cancel same day as appointment --------$50.00

Continued "no shows" or cancellations the same day as the appointment in excess of three instances will be discussed with your physician to determine action necessary.

+ If you have HMO insurance or if your insurance requires a referral, you are responsible for obtaining the referral and presenting referral at the time of "check –in". Our office does not request referrals for you_____INTIALS

+ To refill your medications, you must call your local pharmacy or our office option 2 with 72 hrs./ 3days prior to your medication running out. _____INT

+ After your insurance company has paid their portion of a claim and there is remaining balance, we will send you a statement. Payments are due within 30 days of the statement date. Statements are sent every 30 days. If balance ages past 90 days, your account will be placed in collections _____INT

When diagnostic testing and lab testing is performed our office will call you to discuss your results and further treatment if necessary. Due to HIPPA regulations, we are required to have permission to discuss your health information with anyone beside yourself. If we can discuss your health information with anyone else, please list their information below.

Do we have permission to?

☐ **YES** ☐ **NO** **Discuss your medical condition with family member?**
☐ **YES** ☐ **NO** **Discuss your account with any person answering your home phone?**

1. _____
Name **Phone#** **Relations**

2. _____
Name **Phone#** **Relations**

I _____have reviewed this office's Notice of Privacy Practices and HIPPPA regulations, which explained how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document. _____INITALS

I _____have acknowledged and understand that Dr. Al-Karadsheh has certain affiliations with particular hospitals or an ownership interest in particular healthcare facilities.

I hereby declare that I have read, understand and authorize The Endocrine Center to implement the above regulation of the office and honor my noted request.

_____ _____
Printed Name of Patient/Guardian /Representative **Signature of Patient/guardian/Representative**

_____ _____
Relationship to Patient **Date**

The Endocrine Center Medical History

Patient Name: _____ **Date:** _____

Current medical problems -- Please list the medical problems for which you came to see the doctor:

Referring physician _____ Phone number (_____) _____

Name of pharmacy: _____ Phone number (_____) _____

Please provide a **list of medications** you are now taking; include **frequency and dosage**. Include those you buy without a doctor's prescription such as aspirin, cold tablets, vitamin supplements, etc.

Current allergies, sensitivities, and intolerances. List anything to which you are allergic such as foods, medications, dust, chemicals, bee stings, etc.

Other Medical Care:
Please describe any other illnesses or medical problems you are being treated for; include the name of the physician or mental health practitioner as well as the name of the facility

Please turn over and complete other side.

Past Medical History

Diabetes: Type_____	Yes	No
High Cholesterol	Yes	No
Hypertension (high blood pressure)	Yes	No
Diabetic Foot Exam Date_____	Yes	No
Retinal Exam Date_____	Yes	No
Hypothyroid (underactive thyroid)	Yes	No
Hyperthyroid (overactive thyroid)	Yes	No
Thyroid Nodule	Yes	No
Thyroid Cancer	Yes	No
Coronary Artery Disease / Heart Blockage	Yes	No
Congestive Heart Failure	Yes	No
Osteoporosis / Osteopenia	Yes	No
Prostate Cancer	Yes	No
Breast Cancer	Yes	No
Blood Clots / DVT	Yes	No
Other Cancer Type _____		
Pituitary Problem / Disease	Yes	No
Kidney Stones	Yes	No
Kidney Disease	Yes	No
Chronic Renal Insufficiency	Yes	No
CVA / Stroke	Yes	No
Peptic Ulcer / GERD	Yes	No
Asthma / COPD	Yes	No
Depression	Yes	No
Anxiety	Yes	No

Other Medical History:

_____

_____

_____

_____

Social History

Never smoker	Yes	No
Current every day smoker	Yes	No
Current some day smoker	Yes	No
Former smoker	Yes	No
Alcohol use Quantity_____	Yes	No
Past drug use	Yes	No
Current drug user	Yes	No

Exercise:_____

Occupation: _____

With whom do you live :_____

_____

Family History

Diabetes	Yes	No
Hypothyroidism	Yes	No
Hyperthyroidism	Yes	No
Thyroid Cancer Type_____	Yes	No
Heart Disease (CAD)	Yes	No
Hypertension (high blood pressure)	Yes	No
High Cholesterol	Yes	No
Osteoporosis / Osteopenia	Yes	No
Stroke	Yes	No
Breast Cancer	Yes	No
Prostate Cancer	Yes	No

Other Cancers: Type_____

Other Family History:_____

_____

Surgical History

	Date		
Cataract (eye) surgery		Yes	No
Tonsillectomy (tonsils removed)		Yes	No
Thyroidectomy (thyroid surgery)		Yes	No
Thyroid Biopsy		Yes	No
Breast Biopsy		Yes	No
Mastectomy / Lumpectomy		Yes	No
Coronary Artery Bypass (heart surgery)		Yes	No
PTCA Angioplasty / Stent		Yes	No
Aortic or Mitral Heart Valve Repair		Yes	No
Pacemaker		Yes	No
Appendectomy (appendix removed)		Yes	No
Cholecystectomy (gallbladder removed)		Yes	No
Hysterectomy (total/partial)		Yes	No
Caesarian Section		Yes	No
Tubal Ligation ("tubes tied")		Yes	No
Urinary or bladder surgery		Yes	No
Prostate Surgery		Yes	No
Hernia Repair		Yes	No
Colectomy (colon removal)		Yes	No
Back surgery		Yes	No
Hip surgery		Yes	No
Knee surgery		Yes	No

Other Surgical History:_____

_____

_____

_____

The Endocrine Center Authorization To Release Medical Records

10837 Katy Freeway Suite 200 Houston, TX 77079
Phone 713.468.2122 *Fax 713.468.2289*
www.endocrinecenterhouston.com

Patient Name: _____

Date of Birth: _____ **Date:** _____

Doctor : _____

This letter will serve as authorization for you to provide a copy, summary or narrative of my medical record. Include any information regarding psychiatric history, HIV status and / or drug testing.
As identified by the check mark below.

☐ Complete record

☐ Treatment records from _____ to _____

☐ The first and last five patient encounters – progress notes only

☐ All lab and X-Ray reports for _____

☐ All lab and X-Ray reports

I am requesting the release of records due to _____

_____

Patient signature

2 Ways To Submit This Form:

1) Save the form as a PDF. Print the form and Fax to: 713-468-2289 or bring with you to your next appointment.

2) Save the form as a PDF. Email it to us at info@endocrinecenterhouston.com