Diabetes and Endocrine Associates of Tarrant County, L.L.P.

PATIENT INFORMATION FORM

PHYSICIAN'S NAME

LAST NAME	FIRST	M.I.	MAIDEN NAME
MAILING ADDRESS	APT. NO.	HOME PHONE ( )	
CITY	STATE	ZIP	CELL PHONE ( )
EMPLOYMENT STATUS ☐ FULL TIME ☐ PART TIME ☐ UN-EMPLOYED ☐ SELF-EMPLOYED ☐ RETIRED	☐ STUDENT ☐ FULL TIME ☐ PART TIME	BUSINESS PHONE ( ) ext. #	
SEX ☐ F ☐ M	MARITAL STATUS ☐ SINGLE ☐ DIVORCED ☐ MARRIED ☐ WIDOWED ☐ OTHER_____	DATE OF BIRTH	PATIENT'S SOCIAL SECURITY NO.
PATIENTS EMPLOYERS NAME	PATIENT'S E-MAIL ADDRESS		
EMPLOYER'S ADDRESS			
SPOUSE/GUARDIAN NAME	WORK PHONE	DATE OF BIRTH	SOCIAL SECURITY NO.
EMPLOYER	ADDRESS		
IN CASE OF EMERGENCY CONTACT	RELATIONSHIP	PHONE NUMBER	

PRIMARY INSURANCE COVERAGE

INSURANCE COMPANY	INSURED DOB	☐ SELF ☐ PARENT ☐ SPOUSE ☐ OTHER_____	
INSURANCE CLAIMS ADDRESS	INSURANCE PHONE NO.		
CITY	STATE	ZIP	
NAME OF INSURED	INSURED'S SOCIAL SECURITY NO.		
INSURED'S EMPLOYER	POLICY NUMBER	GROUP NUMBER	

SECONDARY INSURANCE COVERAGE

INSURANCE COMPANY	INSURED DOB	☐ SELF ☐ PARENT ☐ SPOUSE ☐ OTHER_____	
INSURANCE CLAIMS ADDRESS	INSURANCE PHONE NO.		
CITY	STATE	ZIP	
NAME OF INSURED	INSURED'S SOCIAL SECURITY NO.		
INSURED'S EMPLOYER	POLICY NUMBER	GROUP NUMBER	
ANY OTHER INSURANCE COVERAGE ☐ YES ☐ NO	COMPANY NAME	PHONE NUMBER	
WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?	PRIMARY CARE PHYSICIAN		

INSURANCE AUTHORIZATION AND ASSIGNMENT

I authorize Diabetes and Endocrine Associates of Tarrant County , L.L. P. to release to my insurance carrier and/or their agents any information necessary to determine benefits payable for related services. I authorize the payment of medical benefits to Diabetes and Endocrine Associates of Tarrant County, L.L.P.. I understand that I am ultimately responsible for all services whether covered by insurance or not. I also authorize my physician, based on his/her discretion, to access my chart for utilization management review.

DATE: _____ SIGNATURE: _____

Diabetes and Endocrine Associates of Tarrant County, LLP

HIPAA – RELEASE FORM

I, _____, authorize the release of information for
(PATIENT/GUARDIAN NAME)

_____, including the diagnosis, records, billing claim
(PATIENT NAME)

information, examination and treatment render to the above patient.

This information may be released to the following:
(PLEASE PRINT NAME AND PHONE #)

- ☐ Spouse _____
- ☐ Child(ren) _____
- ☐ Other _____
- ☐ Information is NOT to be released to anyone. (Initials) _____

This authorization extends to all records, unless otherwise specified below.

_____

Patient's Name _____ Date of Birth _____

_____ _____ _____
Patient/Guardian Signature Relationship to Patient Date

_____ _____
Witness Signature Date

THIS AUTORIZATION IS VALID UNLESS OTHERWISE NOTED OR REVOKED.

DIABETES AND ENDOCRINE ASSOCIATES OF TARRANT COUNTY, LLP

MEDICAL HISTORY

COMPLETE ALL OF THE FOLLOWING INFORMATION.
All information will be retained in strict confidence and will not be released without legal signed consent.

Last Name **First Name** **MI** **Date of Birth** **Age**

Reason for today's visit: _____

SURGERY: Check all that apply and indicate the approximate date in the blank space.

Appendix _____	Heart Bypass _____	Foot _____	Vasectomy _____
Cataracts _____	Joint _____	Ovaries _____	Hysterectomy _____
Gallbladder _____	Prostate _____	C-Section _____	Tubes Tied _____
Hernia _____	Breast _____	Pregnancy Dates: _____	
Tonsils _____	Other: _____		

MEDICAL PROBLEMS: Check all that apply and indicate approximate date of diagnosis and any specifics in the blank space.

Allergies _____	Diabetes _____	Kidney _____
Anemia _____	Emphysema _____	Migraine _____
Anxiety/Panic Attacks _____	Glaucoma _____	Osteoporosis _____
Arthritis _____	Heart Attack _____	Prostate _____
Asthma _____	Heart Disease _____	Reflux _____
Breast _____	Heart Failure _____	Seizures _____
Cancer _____	High Blood Pressure _____	Sleep Apnea _____
Colon _____	High Cholesterol _____	Strokes _____
Circulation _____	Infertility _____	Thyroid _____
Depression _____	Insomnia _____	Other _____

ALLERGIES to Drugs and X-Ray Dyes: _____

MEDICATIONS: List all medications you are currently taking, those which are prescribed and not prescribed.
Please include over the counter, birth control pills, and any herbs or supplements.

	Drug	**Strength**	**How often you take per day**	**Length of time you have taken**
Example:	*Lipitor*	*10mg*	*1 in morning*	*2 years*

_____
_____
_____
_____
_____
_____

FAMILY HISTORY: Use initial code after the disease to specify who had the disease.
Codes: (M) Mother (F) Father (GP) Grandparent (S) Sister (B) Brother (A) Aunt (U) Uncle

Alcoholism _____	Arthritis _____	Anemia _____	Aneurysm _____	Asthma _____
Breast Cancer _____	Bleeding Easily ____	Colon Cancer _____	Diabetes _____	Epilepsy _____
Glaucoma _____	Gout _____	Hay Fever _____	Heart Attack _____	Hypertension _____
Kidney Disease ____	Mental Illness _____	Migraine _____	Osteoporosis _____	Prostate Cancer ____
Stroke _____	Thyroid Disease ____			

Father:	Living: Y N Age ____ (now or at death)	Present health (now or cause of death): _____
Mother:	Living: Y N Age ____ (now or at death)	Present health (now or cause of death): _____
Brother(s):	Living: Y N Age ____ (now or at death)	Present health (now or cause of death): _____
	Living: Y N Age ____ (now or at death)	Present health (now or cause of death): _____
	Living: Y N Age ____ (now or at death)	Present health (now or cause of death): _____

Sister(s):

Living: Y N Age ____ (now or at death) Present health (now or cause of death): _____
Living: Y N Age ____ (now or at death) Present health (now or cause of death): _____

Son(s): Living: Y N Age ____ (now or at death) Present health (now or cause of death): _____
Living: Y N Age ____ (now or at death) Present health (now or cause of death): _____

Daughter(s): Living: Y N Age ____ (now or at death) Present health (now or cause of death): _____
Living: Y N Age ____ (now or at death) Present health (now or cause of death): _____
Living: Y N Age ____ (now or at death) Present health (now or cause of death): _____

SOCIAL HISTORY:

Marital Status: Single Married Widowed Separated Divorced

Occupation: _____

Check if yes:

Tobacco Currently: How long: _____ How much: _____ What: _____

Have you ever smoked? How long: _____ How much: _____ Quit: _____

Alcohol: Beer: None Occasionally Often Cans per week: _____
Wine: None Occasionally Often Glasses per week: _____
Liquor: None Occasionally Often Ounces per week: _____

Recreational Drugs, including Marijuana: None Occasionally How often per week: _____

Regular Exercise How often: _____ Describe (length & type): _____

Risk for AIDS/Hepatitis: Have you ever had:

Blood Transfusion	Homosexual Relations	Needle Stick
IV Drug Use	Sex with IV Drug User	Work with body fluids

TYPE OF GLUCOMETER: _____ **# OF TIMES TESTED DAILY:** _____

NAME OF:

PCP: _____
OPTHAMALOGIST: _____
OTHER SPECIALIST(S): _____

Please place an X by the current complaint or ailment that applies to you. If unsure, please place a question mark(?).

HEAD:

_____ Blurred vision
_____ Wear glasses/contacts
_____ Glaucoma
_____ Frequent headaches
_____ Migraine headaches
_____ Hearing problems
_____ Constant ringing in ears
_____ Frequent earaches
_____ Sinus infections
_____ Frequent nosebleeds
_____ Hoarse voice, persistent
_____ Mouth or tongue sores
_____ Allergies/hay fever
_____ Lumps or swelling in neck

LUNGS:

_____ Have coughed up blood
_____ Chronic cough
_____ Asthma/wheezing
_____ Emphysema
_____ Increased shortness of breath with activity
_____ History of tuberculosis

KIDNEY:

_____ Urination at night more than once
_____ Brown, black or bloody urine
_____ Have passed kidney stones
_____ Burning upon urination
_____ Difficulty starting stream
_____ Problems with sexual function
_____ Leakage of urine with coughing/sneezing

JOINTS:

_____ Back trouble
_____ Swollen joints
_____ Frequent painful feet
_____ Frequent back or shoulder pain
_____ Persistent aching muscles or joints
_____ Gout
_____ Arthritis

NEUROLOGIC:

_____ Seizures
_____ Loss of consciousness
_____ Double vision
_____ Numbness of hands or feet
_____ Nervousness affecting home life or work

HEART:

_____ Frequent irregular heart beat/racing heart
_____ Chest pain or tightness in chest
_____ Heart murmur
_____ History of enlarged heart
_____ Shortness of breath (lying down at night)
_____ Swelling of feet or ankles present after sleep
_____ History of rheumatic fever
_____ High blood pressure

ABDOMEN:

_____ Frequent heartburn
_____ Have vomited blood
_____ Loss of appetite
_____ Constipation
_____ Rectal pain or bleeding (includes black stool)
_____ Recent change in bowel habits
_____ Hepatitis/yellow jaundice/liver disease
_____ Nausea
_____ Difficulty or pain in swallowing
_____ Diarrhea, frequent
_____ Suspect ulcers
_____ Abdominal pain or nausea with fatty food

GENERAL:

_____ Diabetes
_____ Weight change more than 10 lbs. in last year
_____ Loss of interest in eating
_____ Sleeping difficulty
_____ Thyroid problems
_____ Blood pressure problems
_____ Mole/Sore not healing
_____ Hot or cold natured
_____ Suspect serious disease or cancer
_____ Leg cramps while walking
_____ Thirstier lately
_____ Fatigue
_____ Frequent crying spells, depression
_____ Work or family problems
_____ Anxiety
_____ Anemia
_____ High cholesterol
_____ Change in hair, skin and/or nails

MALES ONLY:

_____ Weak urine stream
_____ Painful or sore genitals (privates)
_____ Prostate trouble
_____ Hard to empty bladder completely
_____ You do testicular self-exams
_____ Other _____

FEMALES ONLY:

_____ Last menstrual period _____
_____ Vaginal discharge
_____ Painful or sore genitals (privates)
_____ Lumps or pain in breasts
_____ Other _____
_____ OB/GYN Name: _____
_____ Last mammogram _____
_____ You do breast self-exams

DOCTOR'S NOTES/COMMENTS