Diabetes and Endocrine Associates of Tarrant County, L.L.P.
1325 Pennsylvania Avenue, Suite 560
Fort Worth, Texas 76104
(817) 820-2890 • Fax (817) 810-0725

Endocrinologists
Stella T. Hecker, M.D.
Kenneth A. Mair, M.D.
Sarah C. Nelson, M.D.
David B. Wilson, M.D.

Diabetes Educators
Nancy Bristow, BSN, R.N., CDE

Dear Patient:

Welcome to Diabetes and Endocrine Associates of Tarrant County, L.L.P. We are pleased to have the opportunity to assist with your medical care. To help you obtain the maximum benefit out of your visit with us, we have enclosed forms for you to complete and bring with you to your appointment. You will also need to bring your current medical insurance card(s) and a photo ID, such as your Driver's License.

Included in this packet, you will find a Patient Information Form and a Medical History form. An Authorization to Release Protected Health Information is being provided should you want us to be able to release any information concerning your healthcare to anyone other than you or your treating physicians. These forms will become a part of your medical record in our office. Our Patient Brochure should answer any additional questions about our office policies.

Listed below are some additional items that should be brought to your initial appointment, if applicable:

1) All Medications and supplements: A listing of your medications, along with the dosage that you take each day is acceptable.

2) Recent lab and/or X-ray reports, and any other pertinent medical notes from your referring physician help prevent the doctor from duplicating tests that have already been done, and to more quickly evaluate your condition.

3) If you are diabetic, please bring your glucose meter, logbook and test strips that you are currently using.

If you are a member of a managed care plan that requires you to have a referral or authorization number to see a specialist, please contact your Primary Care Physician (PCP) *at least 10 days* prior to your appointment to obtain this number. This referral number is required, in order for your visit to be covered by your insurance.

We ask that you arrive **at least 30 minutes prior** to your scheduled appointment, so that we can finalize your registration forms, and to confirm your referral, if necessary.

Please note that we confirm appointments two (2) business day prior to your appointment. *If you do not hear from our office, please call before 4pm to confirm your appointment.* If you have any further questions, please contact our office at (817) 820-2890, option 5 for the Appointment Desk.

Sincerely,

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

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 ☐ NOT-EMPLOYED ☐ SELF-EMPLOYED ☐ RETIRED		☐ STUDENT ☐ FULL TIME ☐ PART TIME	BUSINESS PHONE ( ) ext. #
SEX ☐ F ☐ M	MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ OTHER ☐ DIVORCED ☐ WIDOWED	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, L.L.P.

Authorization to Release Protected Health Information

I, _____, hereby authorize the health records of _____,
Patient and/or Guardian **Patient's Name**

to be disclosed or released to the following person and / or persons by any of the following means: **mail, fax and/or oral**

Name	**Address / Phone #**	**Relationship**
Name	**Address / Phone #**	**Relationship**
Name	**Address / Phone #**	**Relationship**

My authorization extends to any and all records, unless otherwise marked below.

☐ Progress Notes
☐ Records of all visits
☐ Photographs, digital, or images
☐ Statements of charges or payments
☐ Consultation Reports
☐ Discharge Summary
☐ History and Physical Examination
☐ Copies of records or reports provided to the above named (i.e. hospital, lab, clinic, etc.)
☐ Other (must be specific): _____

I understand that records pertaining to the diagnosis and/or treatment of HIV/AIDS, psychiatric illness, alcohol or chemical abuse and dependency will not be released, unless I have given my specific consent to release this information below.

I consent to the release of any positive or negative test result for HIV/AIDS, antibodies for AIDS, or infection with any other causative agent of AIDS or psychiatric illness, alcohol or chemical abuse and dependency with the rest of my medical records.

Patient Signature: _____ **Date:** _____

This authorization or release is given freely with the understanding that:

1. All records, whether written or oral or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law.
2. A photocopy or fax of this authorization is as valid as this original.
3. I may revoke this authorization at any time, except where information has already been released. To revoke my authorization, I must submit a Revocation of Authorization to Release Medical Information Form. Physicians' Office will act upon my revocation within two (2) working days of receipt.
4. Physicians' Office, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.
5. Information used or disclosed pursuant to the authorization may be subject to disclosure by the recipient and may no longer be protected by this rule.
6. Physicians' Office will not condition my treatment, payment, enrollment, or eligibility for benefits on whether I provide authorization for the requested use or disclosure.
7. The patient may inspect or have a copy of the Protected Health Information (PHI) to be used or disclosed.
8. The patient may refuse to sign this authorization; however, PHI will not be released to anyone other than the patient.
9. If Physicians' Office uses or discloses your PHI, it may result in a charge to a Third Party entity.
10. The patient will be provided with a copy of this authorization upon request.

_____	_____	_____
Patient's Printed Name	**Date of Birth**	**Witness (only if marked with an X)**
_____	_____	_____
Patient or Guardian Signature	**Signature Date**	**Relationship to Patient**
		_____
This authorization is valid unless otherwise noted or revoked.		**Expiration Date**

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