New Patient Paperwork

Thank you for choosing Northeast Florida Endocrine & Diabetes Associates. Please fill out this form completely so we may provide excellent healthcare to you. We may ask you to update this information in the future to ensure your information is kept up-to-date.

Patient Name: Last First Middle Initial	Date of Birth Patient's Social Security Number
Address	City State Zip Code
Home Phone Work Phone Cell Phone	Preferred Contact Number ____________________ Patient's Email
Sex: (please circle) Male Female Transgender Ethnicity Race	Marital Status: (please circle) Single Married Separated Divorced Widowed Partner
Student: (please circle) Full Time Part Time Not Student	Parent / Legal Guardian Name & Phone Number
Occupation How long	Employer
Emergency Contact Name & Relation	Emergency Contact Phone Number
Primary Care Physician Name	Primary Care Physician Number & Address
Primary Insurance Company	Secondary Insurance Company
Primary Insurance Policy Number	Secondary Insurance Policy Number
Primary Insurance Group#	Secondary Insurance Group#
Subscriber Name & Address (if different from patient's)	Subscriber Social Security Number & Date of Birth
Relationship To Insured: (please circle one) Self Husband Wife Parent Other__________________________	

Authorization Form

1. Welcome:

We welcome you to our specialty practice of endocrinology. In our effort to provide quality healthcare, it is important to maintain a consistent patient-physician working relationship. For this reason, as endocrine physicians, we expect that all our patients be diligent in keeping all of their scheduled appointments. Endocrine problems require ongoing care and failure to do so may result in complications which can be irreversible. Continuity of care is essential in the successful management of endocrine diseases. Therefore, failure to maintain this relationship by consistently missing scheduled follow up appointments will result in discharge from this practice. I have read and understand my obligation to maintain the quality of my healthcare and understand that if I consistently miss scheduled follow up appointments recommended by my endocrinologist that the consequence will result in discharge from Northeast Florida Endocrine & Diabetes Associates.

____

Signature of Patient / Legal Guardian

2. Consent for Treatment:

The patient and/or authorized representative of the patient, whose signature is affixed below, does hereby consent to any medical treatment which may be deemed advisable by the patient's physician. The intention: hereof being to grant authority to administer and perform all singular exams, treatment and diagnostic procedures which may now or during the course of care be deemed necessary.

____

Signature of Patient / Legal Guardian

3. Authorization to Release Information/ Assignment of Insurance and Medicare Benefits:

I hereby authorize Northeast Florida Endocrine & Diabetes Associates, PA to release any medical or other information necessary to my insurance company to process claims for medical care, diagnostic testing and/or treatment provided to me by Northeast Florida Endocrine & Diabetes Associates, PA. I agree to complete any additional forms which may be required by my insurance in order to process claims. I hereby authorize payment directly to Northeast Florida Endocrine & Diabetes Associates of benefits otherwise payable to me for medical services incurred. In making this assignment to the physician, I understand and agree that any unpaid balances not covered by this policy will be payable by me. I am aware that I am fully responsible for the entire balance in full.

____

Signature of Patient / Legal Guardian

4. Self Pay Agreement:

I have agreed to accept full responsibility for payment for any charges incurred to Northeast Florida Endocrine & Diabetes Associates, and have agreed to pay for these services in full at time of service.

____

Signature of Patient / Legal Guardian

5. POS/Participating HMO Patients:

It is the responsibility of the patient to obtain prior authorization from your primary care physician before each visit to our office. I understand that if this is not done, I will be responsible for any unpaid balance due.

____

Signature of Patient / Legal Guardian

Patient Name: ______________________________________ DOB: _______________________

Acknowledgment of Receipt of Notice

Cancellation & Prescription Policy

I acknowledge that I have had the opportunity to review a copy of NEFEDA's Cancellation and Prescription Policies. By signing below, you agree and understand the terms and conditions stated within these policies.

Patient Signature: __________________________________ *Date:* ______________

For Use and Disclosure of Protected Health Information

By signing this form, I consent to the use and disclosure of my PHI to carry out treatment, payment and healthcare operations (TPO). This consent may be revoked by submitting a request in writing. If I decline to sign this consent, this practice may decline to provide treatment.

Patient Signature: __________________________________ *Date:* ______________

Obtaining External Rx History

I give my full permission to Northeast Florida Endocrine &Diabetes Associates to retrieve my external Rx history from my pharmacy.

Patient Signature: __________________________________ *Date:* ______________

Laboratory & Financial Policy

I acknowledge that I have reviewed a copy of the Laboratory and Financial Policies. By signing below, you agree and understand the terms and conditions stated within these policies.

Patient Signature: __________________________________ *Date:* ______________

HIPAA

I acknowledge that I have had the opportunity to review a copy of NEFEDA's Notice of Privacy Practices ("Notice"). I understand that I am responsible to read this Notice and notify NEFEDA, in writing, of any request for restrictions in the use or disclosure of my PHI. I understand NEFEDA has the right to revise this Notice at any time and will post a copy of the current Notice in the office in a visible location at all times and on their website at: www.nefeda.com. NEFEDA will provide me with a copy of its most recent Notice upon my request.

Patient Signature: __________________________________ *Date:* ______________

Consent for Medical Information Release

There are times we are asked to give family members or others information regarding you and your treatment. If you would like for us to give out information, please fill in the name of the individual and their relationship to you. Please designate which type of information each person may receive by circling the items we may release.

Name(s) of others authorized to discuss or request medical information:

Name: ______________________________ *Relationship:* __________________________

Circle: All info Appointments only STD's/HIV

Name: ______________________________ *Relationship:* __________________________

Circle: All info Appointments only STD's/HIV

To view a complete copy of our policies, please visit www.nefeda.com > Patient Information > Consents/Policies.

Medical Form

Please list your reason/ reasons for your visit:

1.
2.
3.

Please provide us a list of medications you are currently taking, both prescribed and over the counter medicines. Please remember to inform us at each visit any new medications you are taking or medications you have stopped taking.

Medication / Dose	Frequency

Please list any surgeries or hospitalizations you have had.

Surgery/Hospitalization: ____________________ Date ________

Surgery/Hospitalization: ____________________ Date ________

Surgery/Hospitalization: ____________________ Date ________

Surgery/Hospitalization: ____________________ Date ________

Please list social history.

Drinks per week__________ (Alcohol: Beer, Wine, Hard Liquor) Coffee/Tea per week__________ Sodas per week__________

Excersice regularly__________ Type of exercise__________ Frequency__________

Level of education__________ Tobacco products per day_______ Number of years smoking_______

Quit date (If applicable)_______

Please list all allergies, and the reaction you experienced.

1. ____________________ Reaction ____________________

2. ____________________ Reaction ____________________

3. ____________________ Reaction ____________________

4. ____________________ Reaction ____________________

Health History Form

Please check all that apply to you.

	Yes	No
Chest pain		
Swollen ankles		
Shortness of breath		
Recent weight loss, fever, night sweats		
Persistent cough, coughing up blood		
Bleeding problems, bruising easily		
Sinus problems		
Difficulty swallowing		
Diarrhea, constipation, blood in stool		
Frequent vomiting, nausea		
Change of appetite		
Neck, back or joint pain		
Muscle weakness, cramps		
Headaches		
Hoarseness, sore throat		
Blurred vision		
Seizures		
Excessive thirst		
Frequent urination		
Significant fatigue		
Rashes or skin problems		
Joint pain, stiffness		
Heart disease		

	Yes	No
Heart attack, heart defects		
Heart murmurs		
Stroke, hardening of arteries		
High blood pressure		
Low blood pressure		
Thyroid disease		
Hepatitis, other liver diseases		
Stomach problems, ulcers		
Head & neck radiation		
Tumors, cancer		
Adrenal disease		
Eye disease		
Numbness, tingling, pain in legs, feet, hands		
Anemia		
High cholesterol, triglycerides		
Osteopenia or Osteoporosis		
Kidney, bladder disease		
Diabetes		

Women Only	Men Only	Yes	No
Regular periods	Impotence		
Breast swelling	Loss of sex drive		
Menopause			
Nipple discharge			

Health History Form Continued

If you have had any of the following, please list the date, the doctor, and results.

	Date	Doctor	Result
EKG			
Dilated Eye Exam			
Stress Test			
Diabetes Education			
Pneumonia Vaccine			
Influenza Vaccine			

Family History: Please put a check by all that apply.

	Mother	Father	Brother	Sister	Grandparent	Other
Age (if living)						
Health (G) good (B) bad						
Cancer						
Tuberculosis						
Diabetes						
Heart disease						
High blood pressure						
Stroke						
Epilepsy						
Nervous breakdown						
Asthma, hives, hay fever						
Blood disease						
High cholesterol						
Thyroid disease						
Adrenal disease						
Pituitary disease						
Other health issues not listed						
Age (at death)						
Cause of death						

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

Name: ____ Date: __________________

______ Initial here to decline completing this questionnaire.

Over the last 2 weeks, how often have you been bothered by any of the following problems?
(Please circle your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things.	0	1	2	3
2. Feeling down, depressed, or hopeless.	0	1	2	3
3. Trouble falling or staying asleep or sleeping too much.	0	1	2	3
4. Feeling tired or having little energy.	0	1	2	3
5. Poor appetite or overeating.	0	1	2	3
6. Feeling bad about yourself - or that you are a failure or have let yourself or family down.	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television.	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual.	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself.	0	1	2	3

TOTAL SCORE: ___________

_____ Patient Screening is Negative

_____ Patient referred to PCP for further evaluation and management

Provider Signature: ____