Washington Endocrine Clinic
Patient Registration Form

PATIENT INFORMATION **Please print clearly or type and review for accuracy.**

Name: (First) _____ (MI) _____ (Last) _____

Birth Date ____/ ____/ ____ Age: ____ Social Security No. _____ - _____ - _____ Gender: ☐ M ☐ F

Referring Physician _____ Phone _____
(If another physician encouraged you, or referred you to seek the care of an endocrinologist, then the name and phone number of that physician is needed, regardless of whether you require a referral form. The Clinic will communicate with this physician regarding the plan of care. HMO insurance policies frequently require a referral form.)

HOME ADDRESS Street Address _____ Apt# _____

City _____ State _____ Zip _____

Email _____

Phone contact:home _____ cell _____ work _____

INSURANCE INFORMATION

PRIMARY POLICY
Policy holder: ☐Patient ☐Spouse ☐Parent

Insurance Co. _____

Policy/member number: _____

Group# _____

SECONDARY POLICY
Policy holder: ☐Patient ☐Spouse ☐Parent

Insurance Co. _____

Policy/member number: _____

Group# _____

If your insurance coverage is in your name, please check the "patient box" and skip this area. If your insurance coverage is in someone else's name (*i.e.* spouse, parent), then please supply information about the policy holder.

FINANCIAL RESPONSIBLE PERSON ☐Patient ☐Spouse ☐Parent ☐Other: _____

Policy Holder Name: (First) _____ (MI) _____ (Last) _____

Street Address _____ Apt# _____

City _____ State _____ Zip _____

Phone contact: home _____ cell _____ work _____

Social Security No. _____ - _____ - _____ Date of Birth _____ - _____ - _____

PHYSICIAN-PATIENT RELATIONSHIP AGREEMENT

My signature below serves as my confirmation of having read and understood the following policies for this office

1) CONSENT TO TREAT

I, or the person who represents me, consent to have the medical providers at the Washington Endocrine Clinic provide endocrinology care or treatment to me.

2) FINANCIAL CONTRACT

I hereby authorize the release of any medical information necessary to process claims for my visit. I further authorize payment of medical benefits to The Washington Endocrine Clinic for professional services rendered. I understand I am financially responsible to The Washington Endocrine Clinic for charges not covered by this appointment and responsible for all reasonable costs of collection of any debt balance and any unpaid deficiency, including without limitation, court costs and reasonable attorney's fees incurred.

I further understand that the Washington Clinic is NOT responsible for the misquoting of benefits provided by insurance companies should a claim adjudicate differently than how the Clinic was initially informed.

The complete financial policy is found at www.washingtonendocrineclinic.com. I understand that I must pay any applicable insurance co-pays, co-insurances, and deductibles at the time of the visit.

3) BILLING

Patient invoices for outstanding balance charges shall be paid with a credit card, cash, or money order and I agree to pay such statements within 14 days of the e-mailed invoice. I hereby give permission for invoices to be e-mailed to me for any medical expenses my health insurance policy may require me to pay.

4) **LABORATORY AND TEST RESULTS**

The Clinic partners with Sunrise Laboratories for most blood/urine tests. I understand that if I have a Blue Choice or United Healthcare health insurance policy I am required to go to a LabCorp facility. A follow-up appointment is required to discuss test results. Lab tests results are NOT discussed outside of an office visit.

5) MISSED VISITS

Fees for missed visits are as follows: $75 for a medical visit and $50 for a dietitian visit.

These fees are routinely collected from patients who make appointments, but do not keep them for a variety of reasons. The patient is responsible for all appointments.

Failure to complete medical tests requested by the medical provider at any visit is NOT an acceptable reason to cancel an appointment on the same day it is scheduled. Courtesy e-mail and automated phone reminders of appointments are sent, BUT failure to receive these is NOT an acceptable reason to cancel an appointment on the same day it is scheduled.

6) The NOTICE OF PRIVACY PRACTICES POLICY is found at www.washingtonendocrineclinic.com.

I understand that I can access all policy forms on the Clinic's web site, preview a copy of these forms in the office at the time of registration, and/or ask for a printed copy from the receptionist.

Patient Name (please print)	Date	Patient Signature	(Form version 0116)

HEALTH BACKGROUND INFORMATION

CURRENT MEDICAL CONDITIONS (list previously diagnosed conditions, i.e. diabetes, hypertension)

_____

_____

PREVIOUS MAJOR SURGERIES:

_____

_____

CURRENT REVIEW OF SYSTEMS (please check persistent problems over the past month)

☐ anxiety	☐ depressed mood	☐ join pain	☐ rash
☐ blood in stool	☐ erectile dysfunction	☐ low libido	☐ shortness of breath
☐blood in urine	☐ eye pain	☐ muscle pain	☐stomach pain
☐ bone pain	☐fatigue	☐nausea	☐ trouble swallowing
☐cold intolerance	☐ fever	☐neck pain	☐ visual disturbance
☐ chest pain	☐ headache	☐ night sweats	☐ vomiting
☐constipation	☐ heat intolerance	☐ numbness	☐ weakness
☐ cough	☐hoarseness	☐ pain	☐ weight gain
☐ diarrhea	☐ irregular periods	☐ pain with urination	☐ weight loss

FAMILY HISTORY:

Mother: If deceased, age at death _____.

Medical conditions: _____

_____

Father: If deceased, age at death _____.

Medical conditions: _____

_____

Siblings: Medical conditions: _____

_____

SOCIAL HISTORY:

Occupation: _____

Marital status: ☐ single ☐ married ☐ partnered ☐ divorced ☐ widowed

Tobacco use: ☐ none

☐ currently smoke ___ packs per day OR ___ cigarettes per day, for ___ years.

☐ previously smoked ____ packs per day for ___ years and quit in _____ (year).

Alcohol use: ____ drink(s) per week.

ALLERGIES TO MEDICATIONS:

_____

_____

CURRENT MEDICATIONS:

Medication	Dosage	How often do you take it?