PATIENT REGISTRATION

NAME: _____

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

Home Address:_____

City:_____***State:***_____ ***ZIP:***_____

Home Phone: _____***Work Phone :***_____

Cell phone:_____

Marital Status:__ single/ ___married / __widowed /___ separated / ___divorced

Employer:_____***Occupation:***_____

Emergency Contact Name with whom Medical information can be shared_____***Relationship:***_____

Home phone:_____***Work phone:***_____

Do You Have Medical Insurance? ____NO ____Yes

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

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

Name and address of the Primary care: _____

_____

Ph:_____***Fax:***_____

Referred by:_____

PATIENT AUTHORIZATION

I,_____ HEREBY AUTHORIZE Dr. MONIKA MANNAN TO APPLY FOR BENEFITS ON MY BEHALF FOR COVERED SERVICES RENDERED. I REQUEST PAYMENTS FROM MY INSURANCE COMPANY BE MADE DIRECTLY TO THE ABOVE NAMED PROVIDER. I CERTIFY THAT THE ABOVE INFORMATION I HAVE REPORTED IS CORRECT. OTHERWISE I WILL BE RESPONSIBLE FOR ANY CHARGES INCURED. I FURTHER AUTHORIZE THE RELEASE OF ANY NECESSARY INFORMATION INCLUDING MEDICAL INFORMATION FOR THIS OR ANY RELATED CLAIM, TO THE ABOVE NAMED BILLING AGENT. I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THIS ORIGINAL.

** I ALSO UNDERSAND IT IS THE POLICY OF THIS OFFICE TO CHARGE A $25.00 “NO SHOW” FEE FOR ANY MISSED APPT NOT CANCELLED 24 HOURS IN ADVANCE **

DATE_____ SIGNATURE_____

Consent for treatment: I _____ voluntarily consent to the rendering of care, including treatment and performance of diagnostic tests and procedures.

Release of Information: By signing this form ,you are granting consent to Montgomery Endocrinology, LLC, to use and disclose your Protected Health Information (PHI) for the purpose of treatment, payment and health care operation. Our Notice of Privacy provides more detailed information how we may use and disclose this PHI. You have a legal right to review our Notice of Privacy Practices before signing this consent, and I encourage you to read it in full. It is also available at our website: www.MontgomeryEndo.com.Our Notice of privacy Practices is subject to change. If we change the notice, you may obtain a copy of the revised notice by telephoning the office at 301-251-0662.You have a right to request us to restrict how we use and disclose your PHI for the purpose of treatment, payment and healthcare operations. We are not required by law to grant your request. However, if I decide to grant your request, we are bound by our agreement.

You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your PHI in reliance to your consent.

Patient Signature:_____ Date:_____

Office Policies

Here at Montgomery Endocrinology we strive to offer the best medical care. In order for us to do so, we ask you to kindly go over the following statements. Over the years we have come up with these in order to serve you better:

____ I acknowledge that I am responsible for my copayments & deductibles at the time services are rendered unless other arrangements are made

___ I acknowledge that I am responsible for FULL Charge of my office visit if my insurance is not valid at the time of service and or if I do not have a Valid Referral for the visit.

___ I acknowledge that I am fully aware that any tests ordered for care of my health are deemed necessary and so they are requested. Whether they are covered and paid by my medical insurance is a matter between and my insurance carrier.

___ if I acknowledge that I do not give 24 hours' notice prior to my appointment time., I will be charged a "no show" fee. This fee is not covered by my medical health insurance or Medicare and will be my responsibility. **I am also responsible for remembering my appointment.** The office **may send** a reminder email or give a courtesy appointment reminder call.

___ I acknowledge that if I am 10 minutes late for my scheduled appointment, I might have to reschedule. I understand that due to the nature of medical profession, some patients may unexpectedly need additional time and I am not be seen at the scheduled time.

___ I acknowledge that that if I miss 2 consecutive appointments and or do not follow the recommendations made for my health, I may be asked to seek another physician.

__ I acknowledge that I will follow up with my Primary care physician(PCP) for any routine health care. If I don't have a PCP, I will get one.

___ I acknowledge that I will take care of my prescription needs at the time of my visit. I am aware refills via phone or fax are not encouraged. I may be asked to make an appointment for prescription refills.

___ I acknowledge that I am aware that it is my responsibility to follow up with the office after each and every lab test or diagnostic tests done by me. Tests preferably will not be discussed over the phone.

___ I acknowledge that I am responsible to let the office know about any changes in insurance, phone numbers, address, PCP, promptly, even if I do not have an appointment scheduled.

Patient signature:_____ Date: _____

(By signing, you have acknowledged the company policies above and agree to abide by them)

HEALTH HISTORY

Last Name: First Name DOB:

Reason For Consult:

Medical Problems: Please mark X:___ Diabetes Type 1 ___ Diabetes Type 2 ___ Prediabetes

___ Hypothyroid ___ Hyperthyroid ___ Thyroid nodules ___Thyroid Cancer ___ Hashimoto's
___ High Cholesterol ___ High BP ___ Heart Attack ___ Heart Stent ___Heart surgery
___Osteopenia ___ Osteoporosis ___Calcium issue: ___ Kidney stones ___ GERD
___ Stroke ___Skin problem ___HIV ___ Hepatitis B or C ___ Arthritis
___ Asthma ___COPD ___Depression ___ Mania ___ **Cancer**
___**Pregnant** ___ **Pancreatitis** ___Adrenal problem ___ Pituitary problem
___Other

List Surgeries & Hospitalizations:

Social history: ____ Married, ___Single, ____Widowed, _____ Divorced ___ Smoking : ___ Yes ___ No , ___ Quit ,
___ Alcohol , ___ Amount Per week ___Illegal Drugs: names_: ___ Any children ___Living with others
Exercise: Type & Minutes /week : Occupation:

FAMILY HISTORY:

Medication List:

Name	Dose	Name	Dose
-			
-			
-			
-			
-			

- **ANY Vitamins & Herbal Supplements:**

-

Drug Allergies:

Pharmacy : Local Mail Order (if any):

HEALTH HISTORY Continued Page 2:……
Last Name: First Name DOB:
Diabetes History: Type: Year of Diagnosis:
Are you on insulin: Hba1c:
Name of Glucose Monitor:
Using Free Style Libre_____ or DEXCOM___ or Insulin Pump___
Last Eye Exam: Last foot Doctor Visit:
Last seen a Nutritionist Last Heart Stress test:
Review Of Systems: mark x, last 6 months only
General: ___ Fatigue ___Weight Change (more or loss) ___ Fatigue ___Headaches
Skin: ___ Non healing sores _____Excessive face hair
Eyes:___ Blurry vision ___ Redness ___Droopy eyes
Respiratory: ___ Asthma ___Shortness of breath ___ Cough Others
GI: ___ heartburns ___Nausea ___Vomiting ___Abdominal Pain ___Diarrhea ___Constipation
GU: ___Painful urination ___Blood in urine ___ Frequent urination at night ___Vaginal itching
Endocrine: ___ Feeling hot ___ Feeling cold ___Memory issues ___Acne ___Increased sweating
___Breast Lactation ___Increased face/body hair ___Purple abdominal bruises ___Leg weakness
___ Change in shoe/ring size ___Change in shaving pattern
Musculoskeletal: ___ Joint Pain ___Joint stiffness __Muscle weakness ___ Muscle aches
Neurological: ___tingling ___Tremors/shakes ___Numbness of arms/legs ___Insomnia
Psychiatric: ___ Anxiety ___Depression ___Any suicidal ideations ___Any suicidal plan
Hematologic/Lymphatic: ___Easy bruising ___swollen Glands
Any other symptoms:

HIPPA COMPLIANT REQUEST FOR MEDICAL RECORDS:

This document authorizes you to disclose the following health information concerning the patient _____, whose date of birth is _____ and whose social security number is _____ for the purpose of continuing medical management of the person's health issues.

This authorization applies to the following records:

___ All medical records including, but not limited to, inpatient, outpatient and emergency room treatment, al clinical records, reports, document, correspondence, test results, statements, questionaires /histories, office and doctor's hand written notes, and records received by other physicians. This also includes all CT scans, mammograms, MRI's and other radiological reports that may be available and laboratory results. This also includes and pathology reports available.

___ Laboratory results

___ Radiology results such as CT scans, MRI

___ Pathology reports, FNA reports

___ Office progress notes and any handwritten physician notes

This authorization does not apply to psychiatric, psychotherapy or psychological notes or records.

By signing below I further acknowledge the potential for information disclosed pursuant to this authorization to be subject to re-disclosure by a recipient and not protected under the Health Insurance Portability and Accountability Act of 1966 (HIPAA).

This authorization expires two years from the date signed below.

_____ _____

Signature of Patient ***Date***