Endocrinology Institute of Texas

PATIENT INTAKE FORM

PATIENT INFORMATION

Last Name	First Name		Middle Initial	Preferred name	
Street Address	City	State	Zip Code	Date of Birth	Age
Primary Phone #	Email Address				

☐ Male ☐ Female ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widow

EMPLOYER

Name: ____________________

Address: ____________________

City, State Zip: ____________________

Phone: ____________________

EMERGENCY CONTACT

Name: ____________________

Relationship: ____________________

Phone 1: ____________________

May we share personal medical information? ☐ Yes ☐ No

Preferred Pharmacy

Name: ____________________

Address: ____________________

____

City, State Zip: ____________________

Phone: ____________________

Allergies

____

____

____

____

AUTHORIZATION AND RELEASE: I understand that I am responsible for all costs of medical care at the time of service. I also understand that Dr. Feferman is no longer in contract with any insurance companies. All in house lab work is done through Labcorp. Please contact Labcorp directly at 972-566-7500 regarding billing questions. Any missed appointments or cancellation appointments with less than a 24 hour notice will automatically be charged a $50 fee.

The patient understands and agrees to allow this office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

____ ____________

Patient / Guardian Signature *(If guardian, write name please)* Date

Date: ________________ Patient Name: __________________ DOB: __________
Primary Care Physician: ____________________ Age: ___________

Endocrinology Clinic Patient Questionnaire

Current Medical History:
Briefly describe the reasons why you have come to see the Endocrinologist:

____
____
____
____

Past Medical History: (Please check all that apply)

☐ Diabetes ☐ High Blood Pressure ☐ Thyroid Disease ☐ Pituitary Disease
☐ Heart Disease ☐ High Cholesterol ☐ Depression ☐ Osteoporosis
☐ Others: ____

Please list any past surgical procedures:

1.____
2.____
3.____
4.____

Please list any drug allergies:

1.____
2.____
3.____
4.____

Please list/or attach list of all current medications (both prescription & non-prescription):

1.______________________________ 6.______________________________
2.______________________________ 7.______________________________
3.______________________________ 8.______________________________
4.______________________________ 9.______________________________
5.______________________________ 10.______________________________

Personal History:

Occupation:____
Level of Education: ____
Marital Status: ☐Single ☐Married ☐Widowed ☐Separated ☐Divorced
Do you smoke? ☐No ☐Yes: Number of packs per day? ___ For how many years? ___
Have you quit? ☐No ☐Yes: When? ________
Alcohol History: Number of drinks per day? __________ For how many years? __________
Diet: ☐ Yes ☐ No
Exercise: ☐ Yes ☐ No

Family History:

Who in your family has:	Father	Mother	Brother(s)	Sisters(s)	Others
Cancer					
Thyroid Disease					
Pituitary Disease					
Adrenal Disease					
High Cholesterol					
Diabetes					
Heart Attack					
High Blood Pressure					
Osteoporosis					

Patient's Name: ____________________ DOB: __________

Review of Systems:

General, constitutional	No	Yes
Good general health lately	☐	☐
Recent weight change	☐	☐
Fever	☐	☐
Fatigue	☐	☐

Eyes & Vision	No	Yes
Eye disease or injury	☐	☐
Wear glasses/contacts	☐	☐
Glaucoma	☐	☐
Blurred or double vision	☐	☐

Ear, Nose, Throat	No	Yes
Hearing loss	☐	☐
Ringing the ears	☐	☐
Earaches or drainage	☐	☐
Sinus problems	☐	☐
Nose bleeds	☐	☐
Mouth sores	☐	☐
Bleeding gums	☐	☐
Bad breath/bad taste	☐	☐
Sore throat/voice change	☐	☐
Swollen glands in neck	☐	☐

Heart & Cardiovascular	No	Yes
Heart trouble	☐	☐
Chest pains	☐	☐
Sudden heartbeat change	☐	☐
Swelling of feet/ankles/hands	☐	☐

Respiratory	No	Yes
Frequent coughing	☐	☐
Spitting up blood	☐	☐
Shortness of breath	☐	☐
Asthma/wheezing	☐	☐

Gastrointestinal	No	Yes
Loss of appetite	☐	☐
Change in bowel movements	☐	☐
Nausea/vomiting	☐	☐
Frequent diarrhea	☐	☐
Painful bowel movements	☐	☐
Blood in stool	☐	☐
Stomach pain	☐	☐

Genitourinary	No	Yes
Frequent urination	☐	☐
Burning/painful urination	☐	☐
Blood in urine	☐	☐
Change in force/strain w/ urination	☐	☐
Incontinence/dribbling	☐	☐
Kidney stones	☐	☐
Sexual difficulty	☐	☐
Painful periods	☐	☐
Irregular periods	☐	☐
Vaginal discharge	☐	☐

Musculoskeletal	No	Yes
Joint pain	☐	☐
Joint stiffness/swelling	☐	☐
Weakness of muscles/joints	☐	☐
Muscle pain or cramps	☐	☐
Back pain	☐	☐
Cold extremities	☐	☐
Difficulty in walking	☐	☐

Skin and breasts	No	Yes
Rash or itching	☐	☐
Change in skin color	☐	☐
Change in hair or nails	☐	☐
Varicose veins	☐	☐
Breast pain	☐	☐
Breast lump	☐	☐
Breast discharge	☐	☐

Neurological	No	Yes
Frequent/recurrent headaches	☐	☐
Light headed or dizzy	☐	☐
Convulsions/seizures	☐	☐
Numbness/tingling sensation	☐	☐
Tremors	☐	☐
Paralysis	☐	☐
Stroke	☐	☐
Head injury	☐	☐

Psychiatric	No	Yes
Memory loss or confusion	☐	☐
Nervousness	☐	☐
Depression	☐	☐
Sleep problems	☐	☐

Endocrine	No	Yes
Glandular/hormone problem	☐	☐
Thyroid disease	☐	☐
Diabetes	☐	☐
Excessive thirst/urination	☐	☐
Heat or cold intolerance	☐	☐
Dry skin	☐	☐
Change in hat or glove size	☐	☐

Hemotologic/Lymphatic	No	Yes
Slow to heal after cuts	☐	☐
Easily bruise or bleed	☐	☐
Anemia	☐	☐
Phlebitis	☐	☐
Transfusion	☐	☐
Swollen glands	☐	☐

If you have not had a hysterectomy, please give the date of your last menstrual period ______

Patient sign here: ____________________

Physcian/PA sign here: ____________________

Endocrinology Institute of Texas

HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

PATIENT NAME: ______________________ **DOB:** ____________ **Date:** ____________

PROVIDER, FACILITY, OR INDIVIDUALS AUTHORIZED TO RELEASE, REQUEST, AND DISCUSS PERSONAL HEALTH INFORMATION:

Name: ______________________ Phone: ____________

Address: ______________________ Fax: ____________

AUTHORIZATION AND RELEASE: I, the patient, hereby authorize the Provider, Facility, or Individuals listed above to release, request, and discuss my medical information (appointments, lab/x-ray results, diagnoses, treatments, medications, surgeries, etc.) via postal mail, telephone, fax, or email to the following family members, physicians, clinics and/or hospitals:

NAME: ______________________ Phone [H]: ____________

Relationship: ______________________ Phone [M]: ____________

Address: ______________________ Email: ____________

NAME: ______________________ Phone [H]: ____________

Relationship: ______________________ Phone [M]: ____________

Address: ______________________ Email: ____________

PROVIDER: ______________________ Phone [H]: ____________

Type: ______________________ Fax: ____________

Address: ______________________ Email: ____________

PROVIDER: ______________________ Phone [H]: ____________

Type: ______________________ Fax: ____________

Address: ______________________ Email: ____________

PROVIDER: ______________________ Phone [H]: ____________

Type: ______________________ Fax: ____________

Address: ______________________ Email: ____________

May we identify ourselves over the phone? ☐ **Yes** ☐ **No** **May we leave messages?** ☐ **Yes** ☐ **No**

Length of Authorization: ☐ **6 months** ☐ **1 year** ☐ **3 years** ☐ **From:** ____________ **To:** ____________

Endocrinology Institute of Texas

NOTICE OF PRIVACY PRACTICES

PATIENT NAME: ______________________ **DOB:** ____________ **Date:** ____________

I have received, reviewed, and understand this practice's Notice of Privacy Practices written in plain language. The notice provides, in detail, the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information. This includes, but is not limited to:

- A statement that this practice is required by law to maintain the privacy of protected health information.
- A statement that this practice is required to abide by the terms of the notice currently in effect.
- Types of uses and disclosures that this practice is permitted to make for each of the following purposes: treatment, payment, and health care operations.
- A description of each of the other purposes for which this practice is permitted or required to use or disclose protected health information without my written consent or authorization.
- A description of uses and disclosures that are prohibited or materially limited by law.
- A description of other uses and disclosures that will be made only with my written authorization and that I may revoke such authorization.
- My individual rights with respect to protected health information and a brief description of how I may exercise these rights in relation to:
    - The right to complain to this practice if I believe my privacy rights have been violated, and that no retaliatory actions will be used against me in the event of such a complaint.
    - The right to request restrictions on certain uses and disclosures of my protected health information, and that this practice is not required to agree to a requested restriction.
    - The right to receive confidential communications of protected health information.
    - The right to inspect and copy protected health information.
    - The right to amend protected health information.
    - The right to receive an accounting of disclosures of protected health information.
    - The right to obtain a paper copy of the Notice of Privacy Practices from this practice upon request.

I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices, and to make changes regarding all protected health information resident at, or controlled by, this practice. If changes to the policy occur, this practice will provide me an updated Notice of Privacy Practices upon request.

____ ____________________

Patient / Guardian Signature *(If guardian, write name please)* Date

Endocrinology Institute of Texas

HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

YOUR RIGHTS AND RESPONSIBILITIES

You have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission. You may not be able to revoke this authorization if its purpose was to obtain insurance. In order to revoke this authorization, you must do so in writing and send it to the appropriate disclosing party.

You understand that uses and disclosures already made based upon your original permission cannot be taken back.

You understand that it is possible that information used or disclosed with your permission may be re-disclosed by the recipient and is no longer protected by the HIPAA Privacy Standards.

You understand that treatment by any party may not be conditioned upon your signing of this authorization (unless treatment is sought only to create health information for a third party or to take part in a research study) and that you may have the right to refuse to sign this authorization. Refusal to sign will not affect your ability to obtain treatment except to the extent that the information being released or requested my assist your health care provider in determining the appropriate treatment. Refusal to sign this authorization will not affect your eligibility for benefits.

You will receive a copy of this authorization after you signed it. A copy of this authorization is as valid as the original.

This authorization is effective for the above requested and authorized health care information only. You may ask for and receive a copy of this authorization form.

You have the right to inspect the information you are authorizing to be released. This and other specific rights regarding the handling of your health information are outlined in our Privacy Practices.

The information you are authorizing to be released could be re-released or disclosed by the recipient. Such additional disclosures or releases my not be prohibited by law. We are not responsible for the actions of others who may be provided with information released as a result of this authorization.

Unless otherwise specified by law, we will release only that information which has been created by our employees or agents, including char notes, lab results, summaries, and consultations. Records created by and available from other providers, hospitals, or other care facilities must be obtained directly from those other providers of facilities.

____ ________________

Patient / Guardian Signature *(If guardian, write name please)* Date

Endocrinology Institute of Texas

CONSENT FOR PURPOSES OF TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS

I, _________________________ [Name of Individual] consent to Endocrinology Institute of Texas, “the Practice’s”, use and disclosure of my Protected Health Information for the purpose of providing treatment to me, for purposes relating to the payment of services rendered to me, and for the Practice’s general healthcare operations purposes. Healthcare operations purposes shall include, but not be limited to, quality assessment activities, credentialing, business management and other general operation activities. I understand that the Practice’s diagnosis or treatment of me may be conditioned upon my consent as evidenced by my signature on this document.

For purposes of this Consent, "Protected Health Information" means any information, including my demographic information, created or received by the Practice, that relates to my past, present, or future physical or mental health or condition; the provision of health care to me; or the past, present, or future payment for the provision of health care services to me; and that either identifies me or from which there is a reasonable basis to believe the information can be used to identify me. I understand I have the right to request a restriction on the use and disclosure of my Protected Health Information for the purposes of treatment, payment, or healthcare operations of the Practice, but the Practice is not required to agree to these restrictions. However, if the Practice agrees to a restriction that I request, the restriction is binding on the Practice. I understand I have a right to review the Practice’s Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes my rights and the Practice’s duties regarding the types of uses and disclosures of my Protected Health Information. I have the right to revoke this consent, in writing, at any time, except to the extent that the Physician or the Practice has acted in reliance on this consent.

Patient / Guardian name (print)	Date
Patient / Guardian Signature	Date