

THE ENDOCRINE GROUP, L.L.P.

PATIENT INFORMATION

LAST NAME: _____ FIRST: _____ MIDDLE INIT: _____
ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____
HOME #: (____) _____ - _____ WORK #: (____) _____ - _____ OTHER #: (____) _____ - _____
DATE OF BIRTH: ____/____/____ AGE: _____ SEX: Male ____ / Female ____
SS#: _____ - _____ - _____ PATIENT'S EMPLOYER: _____
MARITAL STATUS: Single ____ Married ____ SPOUSE'S NAME: _____
SPOUSES: DOB: ____/____/____ SS#: _____ - _____ - _____ EMPLOYER: _____
NAME OF PERSON TO CONTACT
IN CASE OF AN EMERGENCY: _____ PHONE #: (____) _____ - _____
PRIMARY CARE PHYSICIAN: _____ ADDRESS: _____
REFERRING PHYSICIAN: _____ REF. PHY'S PHONE #: (____) - _____ - _____

INSURANCE INFORMATION

PRIMARY INSURANCE: _____ ID#: _____
SUBSCRIBER'S NAME: _____ **GROUP #:** _____
SUBSCRIBER'S DATE OF BIRTH: _____ **SUB.'S EMPLOYER:** _____

SECONDARY INSURANCE: _____ ID#: _____
SUBSCRIBER'S NAME: _____ **GROUP #:** _____
SUBSCRIBER'S DATE OF BIRTH: _____ **SUB.'S EMPLOYER:** _____

THIRD INSURANCE: _____ ID#: _____
SUBSCRIBER'S NAME: _____ **GROUP #:** _____
SUBSCRIBER'S DATE OF BIRTH: _____ **SUB.'S EMPLOYER:** _____

NAME OF PERSON(S) YOU AUTHORIZE TO DISCUSS YOUR MEDICAL AND PAYMENT INFORMATION WITH:

(1) _____ Relationship: _____
(2) _____ Relationship: _____
(3) _____ Relationship: _____

CONSENT: I consent to the use or disclosure of my protected health information by The Endocrine Group, LLP, for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct the healthcare operations of The Endocrine Group, LLP. I understand that diagnosis or treatment of me by The Endocrine Group, LLP, may be conditioned upon my consent as evidenced by my signature on this document. Initials: _____

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES: I understand that The Endocrine Group's, LLP, Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that may occur in my treatment, payment of my bills or in the performance of the health care operations of The Endocrine Group, LLP. By signing this document I acknowledge that a copy of The Endocrine Group's, LLP, Notice of Privacy practices has been provided to me. Initials: _____

Cancellation Policy: If you are not able to make your appointment, please notify our office at least one day prior to the appointment. We reserve the right to charge a fee for appointments cancelled on the same day. Initials: _____

Patient's Signature: _____ Date: _____

OFFICE USE ONLY: DR. # _____ ACCOUNT # _____ DATE SCHEDULED: _____ INITIALS: _____

APPOINTMENT DATE: _____ TIME: _____ **UPDATE MADE TO: VERSYS MEDIFILE**