ENDOCRINE PARTNERS

Dr. Lorena Lewy-Alterbaum, M.D., F.A.C.E **Ouri-Atou Diarra, ARNP-BC**
9720 Stirling Road, Bldg. C Ste 111 Cooper City, FL 33024 **P: (954)967-0500 F: (954)967-0778**
www.endocrinepartners.com

PATIENT INFORMATION SHEET

Patient Name: _____

DOB: _____ Sex: _____Marital Status: _____ Email Address: _____

Address: _____

City: _____ State: _____ Zip: _____Home Phone: _____

Cell Phone: _____ Work Phone: _____

Emergency Contact Name & Phone Number: _____

_____

Primary Insurance: _____

Policy#_____ Group#_____

Secondary Insurance_____

Policy #_____ Group#_____

Local Pharmacy: _____

Mail Order Pharmacy: _____

Primary Care Physician:_____Phone:_____

****If someone other than the patient is responsible for payment, please complete this section: ****

Name of Responsible Party: _____

Relationship to Patient: _____ DOB: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____Cell Phone: _____

Assignment of Benefits – Financial Agreement

I hereby give lifetime authorization for payment of insurance benefits to be made directly to ENDOCRINE PARTNERS and any assisting physicians for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collections, and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

Patient Signature: _____Date:_____

PATIENT CONSENT/ACKNOWLEDGEMENT FORM

By signing below, you consent to use and disclosure of your Protected Health Information (PHI) by Lorena Lewy-Alterbaum, M.D., F.A.C.E and/or Ouri-Atou Diarra, ARNP-BC and our staff, and our business associates for treatment, payment, and health care operations. For more detailed descriptions of uses and disclosures for these purposes, please review our "Notice of Privacy Practice." This Notice of Privacy describes your rights and the doctor's duties with respect to your Protected Health Information. You have the right to review our Notice prior to signing this consent. The terms of this Notice may change. If the terms change, you may receive a revised Notice by simply calling the office and requesting a revised copy be sent in the mail or by asking for one at time of your next appointment. You have the right to request that we restrict our uses or disclosures of your protected health information that we are otherwise permitted to make for diagnosis, treatment, payment and health care operations, although we are not required to agree to these restrictions. However, if we disagree to these restrictions, they are binding on us. Finally, you may refuse to consent to the use of our disclosure of your Protected Health Information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Protected Health Information. "Protected Health Information" means health information including demographic information, collected from you, the patient and received by your physician, another health care provider, health plan, employer or health care clearinghouse. This Protected Health Information relates to your past, present, or future physical or mental health conditions. ***I HAVE REVIEWED, UNDERSTAND AND AGREE TO THE CONTENT OF THE NOTICE OF PRIVACY. I CONSENT TO THE USE OR DISCLOSURE OF ANY PROTECTED HEALTH INFORMATION BY DR. LORENA LEWY-ALTERBAUM AND/OR OURI-ATOU DIARRA, ARNP-BC FOR THE PURPOSE OF THE DIAGNOSIS, TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS. I UNDERSTAND THAT MY DIAGNOSIS AND TREATMENT MAY BE CONDITIONED UPON MY CONSENT AS EVIDENCED BY MY SIGNATURE ON THIS DOCUMENT. THIS FORM IS ALSO USED TO OBTAIN ACKNOWLEDGEMENT OF RECIEPT OF OUR "NOTICE OF PRIVACY" OR TO DOCUMENT OUR GOOD FAITH EFFORT TO OBTAIN THAT ACKNOLEDGEMENT.***

Patient Signature: _____ Date: _____

NO SHOW POLICY
THERE IS A $50.00 NO-SHOW/LATE CANCELLATION FEE. ALL APPOINTMENTS MUST BE CANCELLED 24 HOURS IN ADVANCE TO AVOID CHARGES FOR A NO-SHOW/LATE CANCELLATION. INSURANCE WILL NOT COVER NO-SHOW/LATE CANCELLATION OR ELIGIBILTY FEES. THANK YOU FOR YOUR CONSIDERATION.

Patient Signature: _____ Date:_____

ENDOCRINE PARTNERS

ADVANCE DIRECTIVE

TO OUR PATIENTS:
The promotion of healthy lifestyles and the early identification of potential health risk will benefit you and are important to us. With this in mind, the following guidelines have been developed. Please discuss any concerns that you might have with your doctor during your visit.

LIFESTYLE CHANGES:

- **DIET**
- **EXERCISE**
- **ABUSIVE HABITS**
- **INJURY PREVENTION**
- **DOMIESTIC VIOLENCE**
- **DENTAL HEALTH**
- **PHYSICAL EXAMINATION**
- **ROUTINE PHYSICALS**
- **FLU VACCINES**
- **LAB WORK**
- **OTHER STUDIES**
- **FEMALE AND MALE ROUTINE CHECK UPS**

ADVANCE DIRECTIVE:
A living will is a document that advises your family and physicians of your desires should you become unable to make decisions regarding your health care. A health surrogate is a person you designate to make decisions for your health care in the event you are unable to. If you have prepared these documents, please give a copy to your doctor to be included in your chart.

PRIMARY LANGUAGE SPOKE: _____

Please indicate if you would like to review these guidelines with your doctor and/or nurse practitioner.

Patient Signature: _____ Date: _____

PATIENT CONSENT TO RELEASE CONFIDENTIAL INFORMATION TO RELATIVE

I, _____, hereby give consent to_____ (Name and relationship to patient) to obtain the following information (circle the information we can release to the above mentioned person)
Any information pertaining to my: [Lab results] [Medications] Radiology Reports] [Appointments] [Financial Information] [Mental Health] [All of the above]

I, _____, do <u>NOT</u> give consent to any other person but myself to obtain information pertaining my health.

Signature of Patient: _____ Date: _____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL/PROTECTED HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

SUMMARY:

By law, we are required to provide you with our Notice of Privacy Practices (NPP). This Notices describes how your medical information may be used and disclosed by us. It also tells you how you can obtain access to this information.

As a patient, you have the following rights:

1. **The right to inspect and copy your information.**
2. **The right to request corrections to your information.**
3. **The right to request that your information is restricted.**
4. **The right to request confidential communications.**
5. **The right to a report of disclosures of your information.**
6. **The right to a paper copy of this Notice.**

We want to assure you that your medical/protected health information is secure with us. This Notice contains information about how we will insure that your information remains private.

If you have any questions about this Notice, please contact our office manager.
Contact Person: Cyndi G
Phone Number: (954) 967-0500 Ext: 603

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

"I hereby acknowledge that I have received a copy of this practice's NOTICE OF PRIVACY PRACTICES. I understand that if I have questions or complaints, regarding my privacy rights, that I may contact the person listed above. I further understand that the practice will offer me updates to this NOTICE OF PRIVACY PRACTICES should it be amended, modified, or changed in any way.

Patient or Representative Name (Print Name):_____

Patient or Representative Signature: _____

Patient refused to sign because: _____

Patient was unable to sign because: _____

Effective date of this Notice: _____

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Name: _____ Today's Date: _____

Sex: [ ] Male [ ] Female [ ] Other Date of Birth: _____

Allergies	Reaction
1.	
2.	
3.	

Medications taking presently	Dose	Times/Day
1.		
2.		
3.		

Pharmacy Name: _____
Address: _____
Phone Number: _____ Fax Number: _____

Past Medical History

- ☐ Diabetes
- ☐ Cancer _____
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Heart attack
- ☐ Other heart trouble
- ☐ Asthma
- ☐ Pneumonia
- ☐ Stroke
- ☐ Epilepsy
- ☐ Anemia
- ☐ Thyroid problems
- ☐ Chicken pox
- ☐ Valley fever
- ☐ Tuberculosis / (+) skin test
- ☐ Depression/Anxiety
- ☐ Bipolar disorder
- ☐ Glaucoma
- ☐ Sexually Transmitted Diseases (STD)
- ☐ Fractures
- ☐ Sexual Dysfunction
- ☐ Headaches
- ☐ Neck problems
- ☐ Back problems
- ☐ Rheumatoid arthritis
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Esophageal reflux (GERD)
- ☐ Kidney/bladder disease
- ☐ Hepatitis
- ☐ Peptic ulcer
- ☐ Appendicitis
- ☐ Other stomach/bowel disease
- ☐ HIV/AIDS

Immunizations:
- ☐ Polio vaccine (year) _____
- ☐ MMR vaccine (year) _____
- ☐ DPT vaccine (year) _____
- ☐ Chicken Pox Vaccine
- ☐ Flu shot in the last 12 months
- ☐ Pneumovax (year) _____
- ☐ Tetanus (year) _____
- ☐ Hep B vaccine (year) _____

Surgical History

- ☐ Tonsillectomy
- ☐ Knee/hip surgery
- ☐ Shoulder surgery
- ☐ Heart Bypass
- ☐ Back surgery
- ☐ Other: _____
- ☐ Appendectomy
- ☐ Thyroid surgery
- ☐ Prostate surgery
- ☐ Cataract R(__) L(__)
- ☐ Breast surgery/biopsy
- ☐ Other: _____
- ☐ Hysterectomy
- ☐ Gallbladder surgery
- ☐ Vasectomy
- ☐ Hysterectomy
- ☐ Gallbladder surgery
- ☐ Other: _____

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Family History

CIRCLE ALL THAT APPLIES

Mother:	Diabetes	Cancer	Hypertension	Heart Disease	Thyroid	Other: _____
Father:	Diabetes	Cancer	Hypertension	Heart Disease	Thyroid	Other: _____
Brothers/ Sisters:	Diabetes	Cancer	Hypertension	Heart Disease	Thyroid	Other: _____
Children:	Diabetes	Cancer	Hypertension	Heart Disease	Thyroid	Other: _____

Social History

Occupation: _____ Hobbies/Activities: _____

Tobacco:
[ ] Never
[ ] Now
Of packs per day: _____
Age started: _____
[ ] Quit Year quit: _____

Alcohol Use:
[ ] Never or
[ ] Liquor _____ per day/week/month
[ ] Beer _____ per day/week/month
[ ] Wine _____ per day/week/month

FEMALES ONLY: [ ] MENOPAUSE

# of pregnancies:
# of C-sections:
# of vaginal deliveries:
# of miscarriages/abortions:
# of premature deliveries:

During pregnancies, did you have any of the following?
[ ] High blood pressure
[ ] Diabetes [ ] Pre-eclampsia or eclampsia [ ] Other

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Review of Systems

Do you have now any of the following problems related to the following systems? Circle **Y** for YES and **N** for NO.

Constitutional Symptoms:
1. Fever Y N
2. Chills Y N
3. Headache Y N
4. Other: _____ Y N

Eyes:
1. Blurred vision Y N
2. Double vision Y N
3. Pain Y N
4. Other: _____ Y N

Allergic/Immunologic:
1. Hay fever Y N
2. Drug allergies Y N
3. Other: _____ Y N

Neurological:
1. Tremors Y N
2. Dizzy spells Y N
3. Numbness/tingling Y N
4. Other: _____ Y N

Endocrine:
1. Excessive thirst Y N
2. Too hot/cold Y N
3. Tired/sluggish Y N
4. Other: _____ Y N

Gastrointestinal:
1. Abdominal pain Y N
2. Nausea/vomiting Y N
3. Indigestion/heartburn Y N
4. Other: _____ Y N

Cardiovascular:
1. Chest pain Y N
2. Varicose veins Y N
3. High blood pressure Y N
4. Other: _____ Y N

Integumentary:
1. Skin rash Y N
2. Boils Y N
3. Persistent itch Y N
4. Other: _____ Y N

Musculoskeletal:
1. Joint pain Y N
2. Neck pain Y N
3. Back pain Y N
4. Other: _____ Y N

Ear/Nose/Throat/Mouth
1. Ear infection Y N
2. Sore throat Y N
3. Sinus problem Y N
4. Other: _____ Y N

Genitourinary:
1. Urine infection Y N
2. Painful urination Y N
3. Urinary frequency Y N
4. Other: _____ Y N

Respiratory:
1. Wheezing Y N
2. Frequent cough Y N
3. Shortness of breath Y N
4. Other: _____ Y N

Hematologic/Lymphatic:
1. Swollen glands Y N
2. Blood clotting problems Y N
3. Other: _____ Y N

Psychological:
1. Are you happy with your life? Y N
2. Do you feel severely depressed? Y N
3. Have you considered suicide? Y N
4. Other: _____ Y N

Patient Name: _____

Patient Signature: _____ Date: _____

Doctor/PA Signature: _____ Date: _____