PATIENT INFORMATION FORM

Thank you for choosing **METRO DETROIT ENDOCRINOLOGY CENTER,** Please fill out this form completely to ensure the best healthcare service. We may ask you to look over this information from time to time to ensure it is up-to-date.

Patient Name	Date of Birth Social Security Number
Address	City State Zip
Home Phone Mobile Phone Work Phone	Marital Status: *(circle one)* Single Married Separated Divorced Widowed
Sex: *(circle one)* Male Female Transgender	Email address
Primary Care Physician Name/ Phone Number	Race / Ethnicity
Primary Insurance Company	Secondary Insurance Company
Parent / Legal Guardian Name & Phone Number	Emergency Contact Name & Phone Number & Relation
Pharmacy Name	Pharmacy Phone Number & Address

If you are covered under the policy of a spouse, partner, parent, legal guardian, please tell us about them

Subscriber Name	Social Security
Date of Birth	Address (if different from patient's)
Home Phone/Work/Mobile	Email
Employer	Occupation

PERMISSION TO TREAT

PATIENT'S NAME_____

I request and authorize **METRO DETROIT ENDOCRINOLOGY CENTER** and its staff to provide treatment for me. This treatment may include, but is not limited to, routine diagnostic radiology and laboratory procedures, administration of routine drugs and routine medical and nursing care. I authorize my physician to perform other additional or extended services in emergency situations if it may be necessary or advisable in order to preserve my life or health. I understand that my care is directed by my physician, his assistants and other personnel who render care and services to me according to the physician's instructions.

_____ _____

Signature of Patient or Guardian Date

PRIVACY PRACTICES ACKNOWLEDGEMENT

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

_____ _____

Signature of Patient or Guardian Date

I authorize the release of any medical information necessary to process my claims and request payment of benefits to the doctor who accepts assignment. I understand the provider's charge may exceed the insurance payment and if greater than such payment, I will be responsible for that amount.

_____ _____

Signature of Patient or Guardian Date

External Rx History Consent

This form allows our office to retrieve your prescription history of medications dispensed from any pharmacies that are participating with our electronic medical records system. This helps to ensure correct medications and dosages.

Patient Name: _____

DOB: _____

I give my permission to get my External Rx History retrieved from my pharmacy.

_____ _____

Patient Signature/ Date Date

HEALTH HISTORY

PATIENT NAME: _____ DATE OF BIRTH: _____

HAVE YOU EXPERIENCED:

	YES	NO
Chest pain?	☐	☐
Swollen ankles?	☐	☐
Shortness of breath?	☐	☐
Recent weight loss, fever, night sweats?	☐	☐
Persistent cough, coughing up blood?	☐	☐
Bleeding problems, bruising easily?	☐	☐
Sinus problems?	☐	☐
Difficulty swallowing?	☐	☐
Diarrhea, constipation, blood in stools?	☐	☐
Frequent vomiting, nausea?	☐	☐
Difficulty urinating, blood in urine?	☐	☐
Dizziness?	☐	☐
Ringing in ears?	☐	☐
Headaches?	☐	☐
Fainting spells?	☐	☐
Blurred vision?	☐	☐
Seizures?	☐	☐
Excessive thirst?	☐	☐
Frequent urination?	☐	☐
Dry mouth?	☐	☐
Jaundice?	☐	☐
Joint pain, stiffness?	☐	☐

	YES	NO
Heart disease?	☐	☐
Heart attack, heart defects?	☐	☐
Heart murmurs?	☐	☐
Rheumatic fever?	☐	☐
Stroke, hardening of arteries?	☐	☐
High blood pressure?	☐	☐
Low Blood Pressure?	☐	☐
Asthma, TB, emphysema, other lung diseases?	☐	☐
Hepatitis, other liver diseases?	☐	☐
Stomach problems, ulcers?	☐	☐
AIDS?	☐	☐
Tumors, cancer?	☐	☐
Arthritis, rheumatism?	☐	☐
Eye diseases?	☐	☐
Skin diseases?	☐	☐
Anemia?	☐	☐
VD (syphilis or gonorrhea)?	☐	☐
Herpes?	☐	☐
Kidney, bladder disease?	☐	☐
Diabetes?	☐	☐

Please provide us medications you are currently taking, both prescribed and over-the-counter medicines.

PLEASE REMEMBER TO INFORM US AT EACH VISIT ANY NEW MEDICATIONS YOU ARE TAKING OR MEDICATIONS YOU HAVE STOPPED TAKING.

Medication / Dose	Frequency

Please list any surgeries you have had:

Surgery _____ Date (mm/yyyy)_____

Surgery _____ Date (mm/yyyy)_____

Surgery _____ Date (mm/yyyy)_____

Please list social history:

___ Alcohol: _____ drinks per week ___ Exercise ___ Smoking: _____/per day

___ Diet ___ Sexually active Number of years smoking _____

___ Travel outside USA

ALLERGIES

Please list any allergies you have, and the reaction you have experienced

1. _____ Reaction: _____
2. _____ Reaction: _____
3. _____ Reaction: _____
4. _____ Reaction: _____
5. _____ Reaction: _____
6. _____ Reaction: _____

Have you had the following Tests?

	Date	Result
X-Rays		
Colonoscopy		
Mammogram		
Pap Test		
Bone Density		
MRI		
Blood Work		
Prostate Exam		

Have you had the following Immunizations?

Pneumonia Vaccine Year: _____
Tuberculin (TB) Test Year: _____
Diphtheria/Tetanus Year: _____
Hepatitis A Year: _____
Influenza (Flu) Year: _____
BCG Year: _____
Measles/Mumps/Rubella Year: _____
Hepatitis B Year: _____

FAMILY MEDICAL HISTORY:

	Living	Deceased	Age	Illness / Cause of Death
Mother				
Father				
Maternal Grandmother				
Maternal Grandfather				
Paternal Grandfather				
Paternal Grandmother				
Sisters, Brothers (Specify)				
Children (Specify)				

METRO DETROIT ENDOCRINOLOGY CENTER

5250 Auto Club Dr. Ste 200, Dearborn, MI 48126
Phone (313) 203-5300 / *Fax* (313) 982-9942

HIPAA (HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT)

Dear Patient,

According to the new HIPAA Federal Regulations, each patient must be assured that his or her medical records are held in the strictest confidence. In order for **METRO DETROIT ENDOCRINOLOGY CENTER** to comply with these regulations, we ask that you take a moment to complete the following questionnaire.

Your signature and initials are required where requested.

What individuals such as family or friends may we discuss your medical history, test or lab results?

1. _____ (Initials) _____
2. _____ (Initials) _____
3. _____ (Initials) _____
4. _____ (Initials) _____
5. _____ (Initials) _____

What physicians or medical personnel may have access to your medical records?

1. _____ (Initials) _____
2. _____ (Initials) _____
3. _____ (Initials) _____
4. _____ (Initials) _____
5. _____ (Initials) _____

May we leave a message on your machine regarding any test results? ___ Yes ___ No
Please note that our office will leave messages on your answering service regarding any appointments and/or scheduling issues.

I understand that **METRO DETROIT ENDOCRINOLOGY CENTER** will adhere to the regulations as outlined by HIPAA and will follow guidelines as I have outlined them above.

Patient Signature _____ Date _____

METRO DETROIT ENDOCRINOLOGY CENTER

Permission to Communicate my Health Information Electronically

Our office is pleased to inform that we now participate in a health information exchange. As you may be aware, health information exchanges allow for electronic communication and access to your electronic medical record. This electronic access, in turn, supports opportunities for improved continuity of care by physicians and other healthcare personnel who are involved in your care. Most important is that health information exchanges create a means by which healthcare data may be accessed in a shorter period than has been traditionally the case with paper records.

Participation in the health information exchange could give your healthcare provider access to critical information such as your home address, past medical history, surgical history, hospitalizations, family history, social history, vital signs, immunizations, allergies, chronic medical conditions, previous and current medications, laboratory and radiology test results. Of course, your privacy protections through HIPAA would remain and providers will be expected to access information consistent with these rules.

PLEASE INDICATE YOUR CHOICE TO PARTICIPATE OR NOT IN THE EXCHANGE AS PROVIDED FOR BELOW.

______ **YES**, I want to participate to communicate my health information with healthcare professionals involved in my healthcare through the health information exchange. I have been informed about information that will be communicated and have had the opportunity to ask any questions that about this decision. I understand that I have the right to change my mind and can withdraw permission by updating this form by checking the NO section and entering a revised date. If I withdraw permission any information in my electronic medication record will not be accessible by the health information exchange. At that point my doctor will still be able to communicate my information by the standard methods of telephone, fax, U.S. mail and encrypted email.

_____ **NO**, I do not (or no longer) want to participate to communicate my health information with healthcare professionals involved in my healthcare through the health information exchange. I have had the opportunity to ask any questions about this decision. I understand that my information will continue to be stored in my electronic medical record but will not be accessible by the health information exchange. I understand that by not participating it may be more difficult for physicians and other healthcare providers to coordinate my care, especially in an emergency situation or when my physician is not available. My physician will still be able to communicate my information by the standard methods of telephone, fax, U.S. mail and encrypted email.

____

Print First Name, Last Name, DOB

____   _______________________

Signature of Patient or Representative   Date

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