BAYAREA ENDOCRINOLOGY ASSOCIATES

PATIENT REGISTRATION

EMR#_____

How did you hear about our office? _____

First Name: _____ Last Name: _____ Middle Int: ____

Preferred Name: _____

Address: _____ Address 2: _____

(If address is a P.O. Box, please include your street address as address 2)

City, State, Zip: _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Sex: ❍ Male ❍ Female Marital Status: ❍ Married ❍ Single ❍ Divorced ❍ Separated ❍ Widowed

Birth Date: _____ Soc. Sec: _____ Drivers Lic: _____ State_____

E-mail: _____ ❑ I would like to receive correspondences via e-mail.

Employment Status: ❍ Full Time ❍ Part Time ❍ Retired

Employer: _____ Phone: _____

Employer Address: _____

City, State, Zip: _____

Student Status: ❍ Full Time ❍ Part Time School: _____

Preferred Pharmacy: _____

Is patient the responsible party? ❑ Yes ❑ No

Responsible Party: (If patient is responsible party, you do not have to fill this section out)

First Name: _____ Last Name: _____ Middle Int: ____

Address: _____ Address 2: _____

(If address is a P.O. Box, please include your street address as address 2)

City, State, Zip: _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Sex: ❍ Male ❍ Female Marital Status: ❍ Married ❍ Single ❍ Divorced ❍ Separated ❍ Widowed

Birth Date: _____ Soc. Sec: _____ Drivers Lic: _____ State_____

Is responsible party, policy holder for patient? ❑ Yes ❑ No

Primary Insurance Information:

Name of Insured: _____ Relationship to patient: ❍ Self ❍ Spouse ❍ Parent ❍ Other

Insured Soc. Sec: _____ Insured Birth Date: _____ Member #: _____

(if different from Soc. Sec. Number)

Insurance Company: _____ Group #: _____

Address: _____

City, State, Zip: _____

Employer: _____ Phone: _____

Employer Address: _____

City, State, Zip: _____

Secondary Insurance Information:

Name of Insured: _____ Relationship to patient: ❍ Self ❍ Spouse ❍ Parent ❍ Other

Insured Soc. Sec: _____ Insured Birth Date: _____ Member #: _____

(if different from Soc. Sec. Number)

Insurance Company: _____ Group #: _____

Address: _____

City, State, Zip: _____

Employer: _____ Phone: _____

Employer Address: _____

City, State, Zip: _____

PATIENT INTAKE

IN CONSIDERATION OF INSTRUCTIONS AND CARE THAT BAY AREA ENDOCRINOLOGY ASSOCIATES, LLC ("BAEA") PROVIDES TO YOU, YOU ACKNOWLEDGE AND AGREE TO THE FOLLOWING TERMS AND CONDITIONS CONTAINED IN THESE PATIENT INTAKE AGREEMENTS.

SIGN AS INDICATED BELOW:

CONSENT FOR PURPOSES OF TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS:

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

My "protected health information" means health information, including my demographics information, collected from me and created or received by physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is reasonable basis to believe the information may identify me.

I understand I have a right to review the BAEA Notice of Privacy Practices prior to signing this document. The BAEA Notice of Privacy could be provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of BAEA. The Notice of Privacy Practices for Bay Area Endocrinology Associates is also provided at 4816 N. Armenia Ave. Tampa, FL 33603. This Notice of Privacy Practices also describes my rights and the duties of BAEA with respect to my protected health information. BAEA reserves the right to change the privacy practices that are described in the Notice of Privacy Practices.
I may obtain a revised Notice of Privacy Practices by requesting in writing from BAEA or asking for one at the time of my next appointment.

Patient Signature_____ **Date**_____

WAIVER AND HOLD HARMLESS: By signing immediately below, you agree to hold BAEA, its owners, employees, physicians, physician extenders and other associates, harmless for any damages and liability including, without limitation, attorney fees and costs at all levels of pretrial, trial, post-trial and/or appeal related to health issues that are present, or may arise in the future from medications, nutrients, protocols, or other therapies provided by or though BAEA or any of It's healthcare providers, whether disclosed or undisclosed to BAEA.

Patient Signature_____ **Date**_____

PATIENT INTAKE

COOPERATION AGREEMENT: You represent and warrant that you will cooperate with BAEA and It's providers to allow It's providers to perform an accurate examination and evaluation. You represent and warrant that you have submitted to BAEA an accurate and complete Medical History Form. You agree that you have and will respond truthfully, accurately and completely in completing the Medical History Form. You acknowledge that your failure to provide truthful, accurate and complete information to BAEA or It's providers could result in inappropriate or unnecessary treatment and harm to you. You authorize BAEA and Its providers to consult with you and your other health care providers, as appropriate, about information gained in your treatment with BAEA, including information you represent to BAEA in your Medical History Form.

Patient Signature_____ **Date**_____

MEDICAL RECORDS RELEASE: You hereby authorize BAEA to obtain your medical history from your treating providers, including, but not limited to, medical laboratories, diagnostic testing facilities, physicians and pharmacies. In addition, you authorize and instruct BAEA and It's providers to provide medical care and prescribe appropriate therapies and pharmaceuticals based on your consultation with BAEA providers, your Medical History Form, the results of any laboratory tests, and other information you agree to submit to BAEA as requested.

Patient Signature_____ **Date**_____

AGREEMENT TO PAY FOR SERVICES RENDERED: I authorize direct remittance of payment of all insurance benefits, including Medicare, if I am a Medicare beneficiary, to BAEA for all covered medical services and supplies provided to me during all courses of treatment and care provided by BAEA, and/or its affiliated entities or otherwise at its direction. I understand and agree this Assignment of Benefits will constitute a continuing authorization, maintained on file with BAEA, which will authorized and allow for direct payment to BAEA, of all applicable and eligible insurance benefits for all subsequent and continuing treatment, services, supplies and/or care provided to me by BAEA.

Patient Signature_____ **Date**_____

FINANCIAL RESPONSIBILITY: I understand that insurance billing is a service provided as a courtesy and that I am at all times financially responsible to BAEA and or its affiliated entities for any charges not covered by healthcare benefits. It is responsibility to notify BAEA of any changes in my healthcare coverage. In some cases exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by BAEA and/or my healthcare insurer if the submitted claims or any part of them are denied for payment. I understand that by signing this form that I am accepting financial responsibility as explained above for all payment for medical services and/or supplies received.

Patient Signature_____ **Date**_____

PATIENT INTAKE

DISCLOSURE: You understand that the BAEA Providers are physicians may be involved with outside medical services, including telemedicine services. You acknowledge and understand that nothing contained herein requires you to see the BAEA Providers at those outside medical services and that You have the right to choose your health care services.

GOVERNING LAW: These Patient Intake Agreements shall be governed, construed and enforced in accordance with the laws of the State of Florida, applicable to agreements made and to be performed entirely within such state, without regard to principles of conflict of laws. Any disputes arising out of, in connection with, or with respect to these Patient Intake Agreements, shall be adjudicated in a court of competent jurisdiction sitting in Hillsborough County, Florida and nowhere else. You hereby irrevocably submit to the jurisdiction of such court for the purposes of any suit, civil action or other proceeding arising out of, in connection with, or with respect to these Patient Intake Agreements.

ENTIRE AGREEMENT: These Patient Intake Agreements contains the entire understanding of the parties and supersedes and merges all prior and contemporaneous agreements and discussions between the parties. Any and all representations or agreements by any agent or representative of either party not contained in these Patient Intake Agreements shall be null, void and of no effect.

SEVERABILITY: If any provision of these Patient Intake Agreements or the application thereof to any person or circumstances is held invalid or unenforceable in any jurisdiction, the remainder hereof, and the application of such provision to such person or circumstances in any other jurisdiction, shall not be affected thereby, and to this end the provisions of these Patient Intake Agreements shall be severable.

INDEMNIFICATION: You covenant and agree to indemnify, defend, protect and hold harmless BAEA and It's providers and their respective officers, directors, employees, Members, assigns, successors and affiliates ("Indemnified Parties") from, against and in respect of all liabilities, losses, claims, damages, punitive damages, causes of action, lawsuits, administrative proceedings, investigations, demands, judgments, settlement payments, deficiencies, penalties, fines, interest, costs and expenses suffered, sustained, incurred or paid by the Indemnified Parties in connection with, resulting from or arising out of, directly or indirectly, BAEA and/or Its Providers rendering medical care, services, advice and/or treatment.

Patient Signature_____ **Date**_____

BAYAREA ENDOCRINOLOGY ASSOCIATES

DIPLOMATE AMERICAN BOARD OF ENDOCRINOLOGY, DIABETES & METABOLISM

4816 North Armenia Ave. Tampa 33603
PHONE: (813) 876-3636 | **FAX**: (813) 870-0077

2412 Cypress Glen, Suite #101. Wesley Chapel, FL 33544
PHONE: (813) 562-0342 | **FAX**: (813) 701-2474

CONSENT FOR RELEASE OF MEDICAL INFORMATION.

TO THE ATTENTION OF:

_____

_____

_____

Patient Last Name _____ First_____ MI____

Address_____

City_____ State_____ Zip_____

Birth Date____/____/_____ Social Security # _____-_____-_____

_____

I HEREBY AUTHORIZE the above stated facility to release copies of my medical records to Bay Area Endocrinology Associates for the purpose of assisting in the care and treatment of my medical condition.
I AUTHORIZE release of information covering treatment dates of_____through and including_____.

I HEREBY RELEASE the said facility from any liability which may arise as a result of my authorization to release the foregoing records. This authorization covers all my medical records and treatments during the dates indicated.

_____ _____

Patient (or person authorized to consent for a minor or patient who is unable to sign due to a physical or mental incompetency) Date

_____

BAYAREA ENDOCRINOLOGY ASSOCIATES
4816 North Armenia Ave. Tampa FL, 33603
PHONE: (813) 876-3636 FAX: (813) 870-0077

PERSONAL HISTORY AND EVALUATION OF PATIENT HEALTH

Patient Name: _____

REASON OF YOUR VISIT TO THE ENDOCRINLOLOGO: _____

PAST HISTORY (PERSONAL)

Have you had any of these diseases?
Please check.

- □Anemia
- □Alcohol Abuse
- □Prologue steroid use
- □Carpal Tunnel
- □Adrenal Tumors
- □Infertility
- □Eye Laser Treatments
- □Tumors in the Brain/Pituitary
- □High Cholesterol
- □Heart Attack
- □Other Heart Diseases
- □Hepatitis
- □Asthma
- □Cancer
- □Sleep Apnea
- □Brain Spill
- □Abdominal Bleeding
- □High Pressure
- □Ulcer in the Feet
- □Kidney disease
- □Bypass Surgery
- □Low Sugar
- □Mass in the Neck
- □Osteoporosis
- □Low Vitamin D
- □Nerve Attack
- □Thyroid Cancer
- □Stomach ulcers
- □Thyroid disease
- □Potassium (High or Low)
- □Diabetes
- □Emphysema
- □Kidney Stones
- □Calcium (High or Low)

□Another Disease Not Mentioned

_____

Married ( ) **Single ( )** **Divorced ( )** **Separated ( )** **Widow ( )**

PERSONAL HABITS

1. Have you ever smoked □Yes □No · **Have you ever chewed tobacco** □Yes □No # years_____
· Are you a regular smoker now? □Yes □No · If not, when did you quick_____
· Number of cigarettes daily____ □ Cigarettes □Pipes · How many years did you or have smoked _____

2.Select if you drink regularly:
□ Liquor: 1-3oz daily □ More than 3oz daily □Beer -1 bottle per day □ Beer -2 bottles per day
□ Beer -3 bottles or more daily □ Wine -1 daily glass □Wine -2-cups a day □ Wine 3 bottles or more daily

3. Have you ever used any of the following?
□Marijuana □Heroin □Cocaine □LSD □Speed Other _____

OPERATIONS:
List and indicate the approximate date and year

_____
_____
_____
_____

SERIOUS INJURIES: (OTHER THAN THE ABOVE)
List wounds and approximate date:

_____
_____
_____

HOSPITALIZATIONS: (ADDITIONS OF OPERATIONS
List approximate dates and reasons

_____
_____
_____

URGENT CARE ER VISITS:
SAY APPROXIMATE DATE AND RASONES)

_____
_____
_____

RADIATION TREATEMNTS: _____
_____
_____

FAMILY HISTORY	CIRCLE SEX	IF LIVING		IF DECEASED	
		AGE	HEALTH	AGE OF DEATH	CAUSE
Father					
Mother					
SISTERS/BROTHERS	M/F				
	M/F				
	M/F				
	M/F				
	M/F				
WIFE/HUSBAND					
SONS/DAUGHTERS	M/F				
	M/F				
	M/F				
	M/F				
	M/F				

SYSTEM REVIEW

Have you experienced any of these symptoms in the last 3 months constantly, more than 2-3 times a week? Check all **YES** answers, and leave blank all **NO** answers, if you are not sure check with **?**

SKIN
__rash
__Pigmented marks
__Skin tags
__Increase sweating
__Oily skin
__Lump or Growth
__Feet/Leg ulcers
__Swollen lymph nodes
__Changes in skin color
__Face Pallor/Plethora/Flushing
__Purple stretch marks

EYE
__Glasses
__Glaucoma
__Change in Vision(double/blurred)
__Pain in eyes
__Halo around the eyes
__Conjunctivitis

NOSE AND THROAT
__Hoarseness
__Nosebleed
__Sores in mouth
__Poor dentition
__Changes in voice
__Tightness in neck

BREAST
__Lump
__Discharge
__Pain

MUSCULOSKETALL
__Broken bones
__Back pain
__Painful joints
__Sore Muscles
__Muscle weakness

Digestive
__Loss of appetite
__Nausea/vomiting after eating
__Vomiting blood
__Passing Blood on bowels
__Diarrhea
__Constipation
__Black Stools
__Jaundice
__Frequent heartburn
__Frequent nausea/vomiting
__Difficulty swallowing
__Stomach pain
__Stomach Ulcers
__Hemorrhoids

GENITOURINARY
__Difficulty starting urine stream
__Painful urination
__Blood in urine
__Discarte (penile/vaginal)
__Blood or pus in urine
__Unexpected vaginal bleeding after menopause
__Difficulty controlling urine
__Erectile Dysfunction

ENDOCRINE
__Frequent urination
__Unusual Thirst
__Tremors
__Nipple secretion
__Decrease Libido
__Heat or Cold intolerance
__Hair Changes
__Change in ring size
__Change in shoe size
__Breast enlargemt (male)

NEUROLOGIC
__Convulsions/epilepsy
__Migraines
__Frequent headaches
__Fainting
__Lightheadedness
__Dizzines
__Insomnia
__Depressed
__Stroke/Paralysis
__More nervous than average person

GENERAL
__Fever
__Unusual fatigue
__Unusual weakness
__Easy brusing
__Night sweats
__Anemia
__Cancer
__Weight loss
__Weight gain

HEART AND LUNG
__Chest pain
__Shortness of breath
__Blood in sputum
__Cough
__Palpitations
__Wheezing
__Unusual Heart beat
__Heart attack
__Swollen ankles
__Murmur
__Rheumatic fever
__Pneumonia
__Emphysema

BAYAREA ENDOCRINOLOGY ASSOCIATES

MEDICATIONS

LIST EACH DRUG, INCLUDING INSULIN, ITS AMOUNT AND HOW OFTEN YOU TAKE IT

MEDICATION	DOSAGE	MEDICATION	DOSAGE

ARE YOU ALLERGIC TO ANY MEDICATIONS? □YES □NO

If yes , please list medications and the reaction you had to them:

Medication	Reaction

OTHER PATIENT COMMENTS:

_____

_____

_____

_____

BAYAREA
ENDOCRINOLOGY
ASSOCIATES

Name:

Date of Birth:

Preferred Email:

Cell Number:

Home Number:

Pharmacy # and address:

PCP or Referring Provider and Fax Number:

Do you give us permission to send to PCP or Referring Doctor last office visit note? (Circle) Yes No

In order to streamline our appointment confirmation process we will start sending appointment reminders by email, text, and/or voice. Do you give us permission? (Circle) Yes No

You may receive by email invitation to our EMR patient portal.