Notice of Privacy Practices

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

We are required by federal law to maintain the privacy of qualifying medical information and to provide you with a notice of its privacy practices. We will not use or disclose your qualifying medical information except as described below. This Notice of Health Information Practices applies to all qualifying medical information generated and maintained by us.

A. DESCRIPTION OF USES AND DISCLOSURES OF MEDICAL INFORMATION

The following categories describe the ways that we may use and disclose your medical information:

1. **Treatment:** We may use and disclose your medical information for medical treatment purposes. Medical treatment purposes include but are not limited to the provision, coordination or management by us of diagnostic, healthcare and related services, consultation between us and other healthcare providers regarding medical care treatment, or the referral of a patient for healthcare services from us to another healthcare provider. We may need to disclose medical information in order to obtain approval for a recommended treatment plan. We may make disclosure of all or any portion of your medical record information to physician (s), nurses, technicians, medical students and other health care providers who have a legitimate need for the information in connection with your medical care and treatment.

2. **Payment:** We may use and disclose your medical information for payment purposes. Payment purposes include but are not limited to activities involving obtaining insurance benefits, determining eligibility or coverage under insurance policies, the coordination of insurance benefits, the adjudication or subrogation of health benefit claims, risk adjusting amounts, billing, claims management, collection activities, obtaining payment under a contract for reinsurance, related healthcare data processing, medical necessity or coverage review, utilization review and disclosure of information to consumer reporting agencies. Your medical information may be released to an insurance company, third party payer or other entity (or their authorized representatives) involved in the payment of your medical bill and may include copies or excerpts of your medical record which are necessary for payment of your account

3. **Routine Healthcare Operations:** We may use and disclose your medical information during our routine business operations, including quality assurance, utilization review, medical review, internal auditing, accreditation, certification, licensing or credentialing activities, medical research and educational purposes.

4. **Special Circumstances That May Require Release of Medical Information Without Written Consent:**
   - A. Federal, State or Local law in connection with Public Health Activities or concerns.
   - B. Victims of abuse, neglect or domestic violence.
   - C. Health oversight activities as authorized by law.
   - D. Law enforcement purposes in response to a valid subpoena or court order.
   - E. Coroner, Medical Examiners, Funeral Directors.
   - F. Organ Procurement Organizations for the purpose of tissue donation and transplantation.
   - G. Researchers whose clinical research study has received approval which complies with applicable law.
   - H. Prevention or lessen a serious and imminent threat to the health or safety of a person or the public.
   - I. Specialized Government Functions such as: military command authorities if you are in the military or a veteran; national security and intelligence activities; protective services for the President and others; or a correctional facility if you are an inmate.
   - J. Worker's Compensation laws or other similar programs that provide benefits for work related injuries or illnesses.
   - K. As Required by Law.

5. **Family/Friends:** Under certain circumstances, we may disclose information about you to a family member, a close personal friend or any other individual you identify to us, if disclosure of the medical information is directly relevant to that person's involvement in your medical care and treatment. We may also disclose medical information about you to a family member, a personal representative or another person responsible for your care and treatment in connection with notification to such person of your location, general condition or death. In addition, we may disclose information about you to an entity assisting in a disaster relief effort, so that your family can be notified about your condition, status and location.

6. **Reminders:** We may use and disclose your medical information to provide appointment reminders or information about treatment alternatives or other health related benefits or services that may be of interest to you.

7. **Business Associates:** We may use and disclose certain medical information about you to our business associates. A business associate is an individual or entity under contract with us to perform or assist us in a function or activity which necessitates the use or disclosure of your medical information. Examples include: medical transcriptionists, accountants, lawyers, billing companies, and consultants. We require that our business associates protect the confidentiality of your medical information.

8. **Other Uses and Disclosures:** Any other uses and/or disclosures of your medical information will be made only with your authorization. Your authorization may be revoked as desired but must be communicated in writing.

B. **DESCRIPTION OF YOUR MEDICAL INFORMATION RIGHTS:**

All records created and maintained by us relating to your medical care and treatment are our property; however, you have the following rights concerning your medical information:

1. **Right to Inspect and Copy:** You have the right to inspect and copy medical and billing records that we maintain, excluding psychotherapy notes. To inspect and/or copy your medical information, you must submit your request in writing to the medical records clerk in our office. Please allow seven to fourteen days, depending on whether or not your chart is in storage. Pursuant to Oklahoma and federal law, we impose a reasonable, cost-based fee of 50¢ per copied page plus postage costs.

2. **Right to an Accounting of Disclosures:** You have the right to request a list of the disclosures we have made of your medical information. To request this list, you must submit your request in writing to the medical records clerk in our office. Your request must state a time period which may not be longer than six years and may not include dates before April 14, 2003. Your request must state in what form you want the list. Each year, the first copy of the list is free, but each additional list may involve a cost.

3. **Right to Amend:** You have the right to request an amendment to the medical information we have about you if you believe it is incomplete or incorrect. To request an amendment, your request must be made in writing; include a reason for your request and be submitted to the privacy officer. We may deny your request for an amendment for the following reasons: it is not in writing; does not include a reason; the information was not created by us; is not part of the medical information kept by our practice; is not part of the information which you would be permitted to inspect and copy; or in our judgment, the information is accurate and complete as it appears or as it was at the time it was originally recorded. A request for an amendment will be acted on no later than 60 days after its receipt.

4. **Right to Request Restrictions:** You have the right to request a restriction on the information we use or disclose for treatment, payment or health care operations. However, we must receive your restrictions in writing before disclosure. Also, if you restrict our right to use your medical information for treatment, payment or health care operations, we are not required to agree to the restriction and reserve the right to immediately withdraw our services from you and terminate the physician-patient relationship.

5. **Right to Request Confidential Communications:** You have the right to request that we communicate with

you about medical matters in a certain way or at a certain location. For example: only contact you at work, home, by mail, phone, answering machine etc. Your request must be specific and in writing to the privacy officer in our office.

6. **Right to Receive a Copy of this Notice:** You have the right to receive a paper copy of this Privacy Notice.

C. **FOR MORE INFORMATION OR TO REPORT A PROBLEM:** If you have questions and would like additional information, you may contact the Privacy Officer at [ADDRESS], [TELEPHONE]. If you believe your privacy rights have been violated, you may file a complaint with the Privacy Officer or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. There will be no retaliation by us, if you file a complaint. For more information see:

www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

D. **CHANGES TO THIS NOTICE:** We will abide by the terms of this Notice with respect to the manner in which it uses and discloses your medical information. We reserve the right to revise the terms of this notice and to make revised notice provisions effective for all medical information maintained by us. Should we change our policies, you may request a copy of the revised notice provisions from us.

Acknowledgement: I have read, understood, and received a copy of Modern Endocrine's Notice of Privacy Practices and a copy of this form will be retained in my medical chart.

Signed: _____ Date: _____

Printed Name: _____

Financial Policy

In addition to accepting traditional insurance plans and Medicare, Modern Endocrine contracts with numerous, Preferred Provider Organizations [PPOs] and Health Maintenance Organizations [HMOs]. Since each plan is different and constantly updates its providers' participation status, please check with your particular plan to make sure we are currently participating in your network. We ask that you assist us in maximizing your insurance coverage by cooperating fully in all referral, prior-authorization, and pre-certification processes.

***Not all insurance carriers consider certain services a covered benefit*. It is important that you are aware of your insurance policy provisions of coverage.** Maintaining accurate, up-to-date information is the patient's responsibility. Please notify Modern Endocrine of any changes in your insurance or personal billing information. Please bring a current insurance card or any other information that is required by your insurance carrier to every appointment. Maintaining updated information allows your medical claims to be correctly filed and timely processed.

Payment can be made by cash, check, money order, Visa, Discover Card, American Express, or Mastercard. Payment for all co-insurance, deductible, and covered services is due at the time of service unless special payment arrangements have been made.

Modern Endocrine may allow payment plans for patients who have financial concerns. ***Please be aware that charges for the following are billed separately*:**

- Physical therapy
- Durable medical equipment
- Laboratory testing
- Anesthesia
- Hospitalization
- Ambulatory surgery facilities
- Certain radiology

There is a $40.00 fee for any FMLA, disability, or accidental form completed. This fee is charged per form and must be paid before completion.

For patients who require surgery or invasive procedures at Community Hospital North, Southwest Surgical Hospital, please be advised that your physician may have ownership in those facilities. If you wish, you may request another facility.

Sincerely,

Modern Endocrine

Signature below acknowledges receipt of this Financial Policy:

Signature: _____ Date: _____

Relationship if other than patient: _____

MODERN ENDOCRINE

1616 S. Kelly Ave. Edmond, OK 73013

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

Facility/Provider to release records: _____

Patient Name: _____ Date of Birth: _____

Recipient & Purpose of Request: I authorize Provider to disclose my protected health information to the following "Recipient":

Recipient Name: _____ Address: _____

City: _____ State: _____ Zip code: _____ Fax: _____ Phone: _____

For the following purpose: _____

I authorize Modern Endocrine ("Provder") to release or receive my protected health information by written, oral, fax, or email communications to or from the persons or agencies above. This authorization is limited to (check all that apply):

☐ Entire medical record concerning this patient (excluding psychotherapy notes, if any)

☐ Medical record concerning this patient for the following date(s) of service: _____

☐ Other: _____

I understand the following:

- Protected health information is health information that identifies me. The purpose of this authorization is to allow the Provider to share my protected health information as set forth above.
- I understand that this authorization is voluntary and that I have the right to refuse to sign this authorization. If I refuse, my protected health information will not be used or disclosed by Provider except as otherwise permitted by law. Provider may not condition treatment on my providing this authorization for use or disclosure of my medical information. If I refuse to sign this authorization, I will still be eligible to receive medical services by the Provider.
- Subject to certain exceptions, I have the right to revoke this authorization at any time by sending a letter to Provider which gives my name, the date I signed this authorization, and states that I revoke the authorization to use my protected health information. The letter will not affect any actions taken in reliance of my previous authorization.
- This authorization may result in Provider disclosing my medical information to a recipient who could possibly later use or disclose the information without my authorization. Provider cannot control re-disclosure by Recipient.
- I may inspect or copy the information that will be disclosed or used for the purposes set forth in this authorization. I will receive a signed copy of this authorization form and may contact Provider to get a copy if I do not have one.
- **Protected health information authorized for release may include records that indicate the presence of or regarding treatment of HIV/AIDS, sexually transmitted disease, and drug and/or alcohol abuse.**

_____ _____

Signature of Patient or Patient Representative Date

_____

Printed Name of Patient or Patient Representative

Description of Representative's authority (attach documentation):

☐ Parent of a minor ☐ Power of attorney ☐ Legal guardian ☐ Other: _____

This authorization is only effective if it is signed and dated. Unless I revoke this authorization prior to expiration, this authorization expires on _____ (if left blank, one year after the date it is signed).

CONTROLLED SUBSTANCE PRESCRIPTION AGREEMENT

Print Patient Name: _____ DOB:_____

The purpose of this agreement is to prevent misunderstandings about certain medicines the patient will be taking for hormone, anxiety and pain management. This is to help both the patient and their provider comply with the law regarding controlled medications. Please read this contract thoroughly, as it is a condition of your continued treatment. Your signature will be required.

The use of opioids, benzodiazepines, and stimulants may cause addiction, and is only one part of a complete treatment plan.

I agree to the following:

1. I am responsible for my medicines. I will not share, sell, or trade my medicine. I will not take any medicine that is not prescribed for me.
2. Forging or altering a narcotic prescription, or distributing medications to others is a crime. I understand that should any of the above occur, my entire care with this office will be terminated, and I will be reported to law enforcement authorities.
3. Excessive phone calls requesting increased dosages or frequency is viewed as drug-seeking behavior. Changes in my medication will not be made without an office visit.
4. I will not increase my medication until I speak with my doctor or nurse.
5. My medicine may not be replaced if it is lost, stolen, or used up sooner than prescribed.
6. I will keep all appointments set up by my doctor. I will notify my doctor's office at least 24 hours prior to my scheduled appointment if I must cancel. Multiple cancellations, no-shows or rescheduled appointments may be considered non-compliance and may result in my termination as a patient.
7. I will bring pill bottles with any remaining pills of this medicine to each clinic visit if asked.
8. I agree to come to the office for a pill count at any time if asked by my doctor.
9. I will not use any illegal or controlled substances including marijuana, cocaine, or amphetamines, etc.
10. I agree to give a blood or urine sample, if asked, to test for illegal drug and other medication use. I understand that my insurance company might not cover the test, and I will be responsible for the payment. I understand that this test can be very costly. This drug screen may be given at my initial visit, and again randomly through the course of my treatment.
11. I understand that my doctor's office will utilize the Oklahoma Bureau of Narcotics Drug Tracking Program.
12. I have been informed by my physician about narcotic effects, including the normal physiological effect of tolerance (where i might need to take more medication to obtain the same pain relief) and dependence (an uncomfortable withdrawal reaction which may occur if i stop taking medication abruptly), and the abnormal effects of addiction (psychological dependence leading to abnormal behavior), which is very rare in patients with genuine pain.
13. I understand that narcotics can adversely affect my judgment in making business decisions, and in operating equipment such as an automobile.
14. I understand that the main treatment goal is to improve ability to function and/or work, not simply decrease pain. In consideration to that I agree to help myself by following better health habits such as exercising regularly, achieving optimal weight control and limiting my use of unhealthy substances like alcohol and tobacco. I

understand that only by following a healthier lifestyle can I hope to have the most successful outcome from my treatment.

15. I understand that there will be a trial period for this medication regimen. Within this period, my case will be reviewed. If there is no evidence that I am improving, or if progress is not being made to improve my function and quality of life, my medication regime will be tapered and my care will be referred back to my primary care physician.
16. Non-payment of services rendered may result in my office visit being rescheduled. Per this agreement, refills will only be provided at regularly scheduled office visits. If my office visit is rescheduled due to non-payment. I will not receive a refill on my medications.
17. I understand that I am required to be seen in the office for controlled substances every 90 days.

Refills

- I understand that refills of narcotic medication will be given only during my regularly scheduled appointment, or once monthly by telephone if the current prescription has been correctly used. I will call my pharmacy 3 business days in advance and have them fax the request to the office.
- I understand that refills will be made only during regular office hours-Monday through Friday, 8:30AM-4:30PM. No refills will be available on nights, holidays or weekends. Advance notice of 3 days is required.
- I must keep track of my medications. No early or emergency refills may be made. Prescriptions must be filled before expiration.
- I will only use one pharmacy to get my medicine. My doctor may talk with the pharmacist about my medicines. The name and phone number of my pharmacy is_____

Emergencies

In the event of a new injury or significant change in your condition, go directly to the ER or call 911. Patients are responsible for notifying any other physician they see that they may obtain narcotics from this office. Patients are responsible for notifying this office of any treatment received by the ER or another physician. Patients must notify this office if narcotics have been obtained from another physician.

Prescriptions from Other Doctors

If I see another doctor who gives me a controlled substance medicine (a dentist, a doctor from the Emergency Room, another doctor, etc.), I must bring this medicine to the office in the original bottle, even if there are no pills left. I am not to see or accept medications from other providers without my doctor's permission.

Termination of Agreement

If I break any of the rules, if my drug test results are inconsistent with treatment prescribed by my doctors or if my doctor decides that this medicine is hurting me more than helping me, this medicine will be stopped by my doctor in a safe way, and no refills will be made. Further, my physician may dismiss me as a patient of the practice and may ask me to select another physician. Any violation of this contract or counseling received regarding violations will remain a part of my permanent medical record. This contract will remain enforced during the entire course of my treatment plan.

I have talked about this agreement with my doctor and I understand the above rules.

Print Patient Name:_____ **DOB:**_____

Patient's Signature_____**Date:**_____

Physician's Signature_____

MODERN ENDOCRINE

Authorization to Release Information

Name: _____ DOB: _____

I hereby authorize confidential communications from the physicians or staff of this office regarding my healthcare, lab work, test results, treatments, appointments, prescriptions, etc. to be received at any of the phone numbers listed below. I authorize staff to leave messages on the voicemail or with the individual who answers the phone at any of the below numbers:

DO NOT FILL IN NUMBERS AT WHICH YOU DO NOT WISH TO BE CONTACTED

Home Phone: _____ Cell: _____ Other: _____

I authorize the following individuals to call the office on my behalf to verify the status of appointments, treatment plan, medications, and/or account information. These individuals may also pick up prescriptions and/or samples that I have requested.

Name: _____ Telephone: _____ Relationship: _____

Name: _____ Telephone: _____ Relationship: _____

Name: _____ Telephone: _____ Relationship: _____

Name: _____ Telephone: _____ Relationship: _____

Below is the pharmacy that I will use for all prescriptions:

Pharmacy name: _____ Phone number: _____

I understand this authorization will remain in effect until I revoke it in writing.

_____ _____

Patient Signature Date

MODERN ENDOCRINE

CANCELLATION POLICY

Due to high patient demand, Modern Endocrine has a Cancellation Policy that requires patients to cancel their appointments with at least 24 hours' notice.

Patients who do not cancel their appointments with at least 24 hours' notice will be charged $40. A patient's insurance company will not be billed for this fee. If a patient fails to cancel his or her appointment with at least 24 hour's notice three times or more, Modern Endocrine may dismiss the patient from its practice.

We understand emergencies happen. If you schedule an appointment and cancel on the same day, you will not be charged. If a patient cancels three appointments, Modern Endocrine may dismiss the patient from its practice.

Modern Endocrine firmly believes that a good physician-patient relationship is based upon understanding and good communication. Questions about this Cancellation Policy should be directed to the Modern Endocrine Practice Manager.

We appreciate your understanding in this matter.

_____ _____

Patient/Guardian Signature Date

_____ _____

Printed Name Date of Birth

MODERN ENDOCRINE

DISCLOSURE OF FINANCIAL INTEREST

Cassie Smith, M.D., regularly sends specimens collected for laboratory analysis to Total Healthcare Partners Laboratory. Cassie Smith, M.D., has a financial interest in all transactions from this office to Total Healthcare Partners Laboratory. You have a right to have your specimens collected for laboratory analysis sent to any qualified laboratory of your choice, if you so desire. If you desire that your collected specimens be sent to a laboratory other than Total Healthcare Partners Laboratory, please advise the staff of your preferred laboratory.

Modern Endocrine has established a protocol for directing patient lab orders based on the patient insurance.

I understand that each insurance plan has its own criteria for medical coverage and that I will be responsible for payment if testing is not fully covered.

It is the patient's responsibility to inform the phlebotomist each time blood is drawn if they have a preferred lab.

Please circle the laboratory of choice:

☐ TOTAL HEALTHCARE PARTNERS LABORATORY (if insurance is in network)

☐ HEARTLAND (for biopsy purposes)

☐ DLO

☐ OTHER: _____

Please sign below that you have read, understood, and agree to this policy.

Print Name: _____ Date: _____

Patient Signature: _____ Date of Birth: _____

AUTHORIZATION FOR TREATMENT

I hereby authorize the Physician(s) in charge of the care of the patient of The Physicians Group, LLC to administer treatment as may be deemed necessary or advisable in the diagnosis and treatment of this patient.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize the physician(s) of The Physicians Group, LLC to disclose any or all of the information in my medical records to any person, corporation or agency which is or may be liable for all or part of The Physicians Group, LLC charge or who may be responsible for determining the necessity, appropriateness, amount or other matter to the physician's treatment or charge including, but not limited to , insurance companies, health maintenance organizations, preferred provider organizations, workers compensation carriers, welfare funds, the Social Security Administration or its intermediaries or carriers. **I UNDERSTAND THAT MY MEDICAL RECORDS MAY CONTAIN INFORMATION THAT INDICATES THAT I HAVE A COMMUNICABLE DISEASE WHICH MAY INCLUDE BUT IS NOT LIMITED TO, DISEASE SUCH AS HEPATITIS, SYPHILIS, GONORRHEA OR THE HUMAN IMMUNODEFICIENCY VIRUS, ALSO KNOWN AS ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS).** With this knowledge, I give my consent to the release of all information in my medical records, including any information concerning identity, and release The Physicians Group, LLC, its agents and its employees from liability in connection with the release of the information contained therein.

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize payment directly to my physician(s) of the medical insurance benefits otherwise payable to me for services rendered during my visit at The Physicians Group, LLC. I understand I am financially responsible for charges not covered by this assignment.

I agree that, to the fullest extent permitted by law, we may remit all or a portion of any credit balances or other amounts due to you from us to any of our affiliates to whom you have any balance owing for fees, items or services. We will advise you of any payments we make on your behalf to our affiliates.

WAIVER OF RESPONSIBILITY OF VALUABLES

I hereby release The Physicians Group, LLC from any claim for responsibility or damages in the event of loss of my property, including money and jewelry.

I understand a photocopy of this document is as valid as the original.

PRINT NAME_____ **DATE**_____
(Patient)

OR _____ _____
(Nearest relative or responsible party) (Relationship to patient)

POLICYHOLDER'S SIGNATURE _____

NOTICE TO PATIENTS: Information in your medical record that you have/may have a communicable or venereal disease is made a confidential by law and cannot be released without your permission, except in limited circumstances, including release of persons who have had risk exposures, release pursuant to an order of the court of the Dept. of Health, release among healthcare providers or release for statistical or epidemiological purposes. When such information is released, it cannot contain your information from which you could be identified unless release of that identifying information is authorized by you, by an order of the court, or the Department of Health, or by law.

MODERN ENDOCRINE

1616 S KELLY AVE
EDMOND, OK 73013
P: 405-286-1571
F: 405-286-1572

NAME:_____DOB_____ DATE_____

Please answer the following questions

PREVENTATIVE HEALTH

Have you ever had any of the following screenings?

	NO	YES	IF YES, WHEN?	WHERE?
COLONOSCOPY	☐	☐		
SIGMOIDOSCOPY	☐	☐		
STOOL HEMOCCULT	☐	☐		

Have you been immunized against any of the following?

	NO	YES	IF YES, WHEN?
INFLUENZA / FLU	☐	☐	
PNEUMONIA	☐	☐	
SHINGLES / ZOSTAVAX	☐	☐	
TETANUS / DIPHTHERIA	☐	☐	
CHICKENPOX / VARICELLA	☐	☐	
MMR / MEASLES, MUMPS & RUBELLA	☐	☐	
HPV	☐	☐	

SOCIAL HISTORY

TOBACCO USE: What is your smoking status? ☐ Currently ☐ in the past

How many packs per day? ☐ Less than 1 ☐ 1-2 ☐ more than 2

How many years? _____

Do you vape? ☐ Yes ☐ no

Do you use other tobacco products? ☐ Yes ☐ no if yes, what kind _____

ALCOHOL USE: Do you consume alcohol? Yes no

How often do you drink per week? _____ per month?_____

DRUG USE: Do you use street drugs? Yes no if yes then what kind?_____

CAFFEINE: How many servings of caffeine per day do you consume daily? _____

EXERCISE: How often do you exercise weekly? _____

RISK FACTORS:

Do you wear a seatbelt? Always almost always occasionally never
Sun exposure? Rarely occasionally frequently
Do you feel safe at home? Yes no
Are you exposed to secondhand smoke? Yes no

WOMEN

Are you pregnant or trying to become pregnant? YES NO

Do you perform monthly self-breast exams? YES NO

Have you had a mammogram? YES NO When?_____

When was your last PAP?_____ Where?_____

Have you had a bone density scan? YES NO When?_____ Where?_____

Currently ….. Having periods yes no
Menopausal yes no at what age_____
Contraception use abstinence condom IUD foam patch pill ring
Hysterectomy tubal sterilization vasectomy Depo-Provera

MEN

Do you perform a monthly self-testicular exam? Yes no

Do you have erectile dysfunction concerns? Yes no

Would you like to discuss hormone treatment? Yes no

Have you had a PSA level checked in the past? Yes no

SURGERIES

No past surgeries ☐

☐ ABDOMINAL when?_____ ☐ HERNIA when?_____
☐ ADRENAL when?_____ ☐ HIP _____ when?_____
☐ APPENDECTOMY when?_____ ☐ HYSTERECTOMY when?_____
☐ BACK when?_____
☐ LEG _____ when?_____
☐ BLADDER when?_____ ☐ LUNG when?_____
☐ BREAST RECONSTRUCTION when?_____ ☐ MASTECTOMY when?_____
☐ BREAST REDUCTION when?_____ ☐ OVARIES _____ when?_____
☐ C-SECTION when?_____ ☐ KIDNEY _____ when?_____
☐ CANCER _____ when?_____ ☐ KNEE _____ when?_____
☐ CATARACT when?_____ ☐ NECK when?_____
☐ COLON when?_____
☐ PITUITARY when?_____
☐ EAR _____ when?_____ ☐ PROSTATE when?_____
☐ EYE _____ when?_____ ☐ SHOULDER_____ when?_____
☐ FOOT _____ when?_____ ☐ SINUS when?_____
☐ GALLBLADDER when?_____ ☐ THYROID when?_____
☐ HAND when?_____
☐ TONSILLECTOMY when?_____
☐ HEART BYPASS when?_____ ☐ TUMMY TUCK when?_____
☐ OTHER _____

YOUR MEDICAL HISTORY

☐ ACROMEGALY
☐ ADRENAL INSUFFICIENCY
☐ ANEMIA
☐ ANXIETY
☐ HISTORY OF TAKING STEROIDS
☐ INFERTILITY
☐ INSULIN PUMP USE
☐ INSULIN RESISTANT

☐ ASTHMA
☐ AUTOIMMUNE DISORDER
☐ BLADDER INFECTION
☐ BLEEDING DISORDER
☐ BLOOD CLOTS
☐ CANCER _____
☐ DEPRESSION
☐ DIABETES TYPE I OR TYPE 2
☐ GALLBLADDER
☐ GASTROINTESTINAL DISORDER
☐ HEART DISEASE
☐ HEPATITIS
☐ HIGH BLOOD PRESSURE
☐ HIGH CHOLESTEROL
☐ CURRENTLY ON HORMONE THERAPY

☐ KIDNEY DISEASE
☐ LIVER DISEASE
☐ MIGRAINE HEADACHES
☐ OSTEOPOROSIS / OSTEOPENIA
☐ OVARIAN CYSTS
☐ PARATHYROID DISORDER
☐ PITUITARY DISORDER
☐ SEXUAL DIFFICULTY
☐ STROKE/ CVA
☐ THYROID DISORDER
☐ THYROID NODULE
☐ TUMORS
☐ URINARY PROBLEMS
☐ WEIGHT DISORDER

SYMPTOMS YOU ARE CURRENTLY HAVING: (circle what applies to you)

GENERAL: ☐ fever ☐ weight loss ☐ weight gain ☐ fatigue ☐ frequent infections ☐ low sex drive

EYES: ☐ visual disturbances ☐ wearing glasses or contacts

EAR, NOSE, THROAT: ☐ hearing loss ☐ sinus pain ☐ seasonal allergies ☐ mouth sores

CARDIOVASCULAR: ☐ chest pain ☐ shortness of breath with exertion ☐ palpitations ☐ swelling hands/ feet

RESPIRATORY: ☐ wheezing ☐ chronic cough ☐ shortness of breath ☐ coughing up blood

BREAST: ☐ mass/lump ☐ breast pain ☐ nipple discharge

GASTROINTESTINAL: ☐ nausea ☐ vomiting ☐ constipation ☐ chronic diarrhea ☐ abdominal pain ☐ bloody stools ☐ hemorrhoids ☐ excessive gas ☐ indigestion ☐ change in bowel habit

FEMALE ONLY: ☐ urinary frequency urgency or pain with voiding ☐ vaginal dryness discharge or itching/burning ☐ painful intercourse ☐ painful menstruation ☐ urine leakage ☐ blood in urine

MALE ONLY: ☐ urinary frequency ☐ urgency or pain with voiding ☐ impotence ☐ urine leakage ☐ blood in urine

MUSCULOSKELETAL: ☐ joint pain ☐ muscle pain ☐ muscle weakness

SKIN: ☐ dry skin ☐ rash ☐ hives ☐ open skin sore ☐ discoloration of skin

NEUROLOGIC: ☐ fainting ☐ decreased memory ☐ numbness ☐ trouble walking ☐ headaches

PSYCHIATRIC: ☐ anxiety ☐ frequent crying ☐ fearful ☐ depression ☐ change in sleep pattern

ENDOCRINE: ☐ hair changes ☐ heat intolerance ☐ cold intolerance ☐ hot flashes

FAMILY MEDICAL HISTORY

Family history unknown ☐

	mother	father	sister	brother	daughter	son
ADRENAL INSUFFICIENCY	☐	☐	☐	☐	☐	☐
BREAST CANCER	☐	☐	☐	☐	☐	☐
LUNG CANCER	☐	☐	☐	☐	☐	☐
COLON CANCER	☐	☐	☐	☐	☐	☐
THYROID CANCER	☐	☐	☐	☐	☐	☐
OTHER CANCER	☐	☐	☐	☐	☐	☐

	mother	father	sister	brother	daughter	son
BLEEDING DISORDER	☐	☐	☐	☐	☐	☐
BLOOD CLOTS	☐	☐	☐	☐	☐	☐
HIGH BLOOD PRESSURE	☐	☐	☐	☐	☐	☐
HEART DISEASE	☐	☐	☐	☐	☐	☐
HEART ATTACK	☐	☐	☐	☐	☐	☐
THYROID DISEASE	☐	☐	☐	☐	☐	☐
DIABETES	☐	☐	☐	☐	☐	☐
OSTEOPOROSIS	☐	☐	☐	☐	☐	☐
OSTEOPENIA	☐	☐	☐	☐	☐	☐
RESPIRATORY DISEASE	☐	☐	☐	☐	☐	☐
KIDNEY DISEASE	☐	☐	☐	☐	☐	☐
SEIZURES	☐	☐	☐	☐	☐	☐
STROKE	☐	☐	☐	☐	☐	☐
DEPRESSION	☐	☐	☐	☐	☐	☐
ANXIETY	☐	☐	☐	☐	☐	☐

OTHER_____

ALLERIGES_____
_____

PCP NAME_____PHONE_____

PHARMACY_____

MEDICATION:_____

_____

_____

_____

_____

_____

_____

_____

MODERN ENDOCRINE

1616 S Kelly Ave. Edmond, OK 73013 | Phone: (405) 286 - 1571 | Fax: (405) 286 - 1572

New Patient Registration Form

PATIENT INFORMATION

Name (Last, First, Middle): _____ Maiden: _____

Address: _____ City: _____ State: _____ Zip: _____

DOB: _____ SSN: _____ Phone: (_____)_____

Email Address: _____ Occupation: _____ Employer: _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed Sex: _____ Male _____ Female

Spouse (Last, First, Middle): _____ Maiden: _____

Emergency Contact: _____ Relationship: _____

Emergency Contact Phone: (_____)_____

If the Patient is a minor (under the age of 18), please provide information for the parent or legal guardian.

Parent/Legal Guardian Name: _____ Phone: (_____)_____

INSURANCE INFORMATION

Primary Insurance Company

Name: _____ Policy ID#: _____

Plan: _____ Group #:_____

Policy Holder's Name: _____ Policy Holder's DOB: _____

Policy Holder's Employer: _____ Relationship to Patient: _____

Secondary Insurance Company

Name: _____ Policy ID#: _____

Plan: _____ Group #:_____

Policy Holder's Name: _____ Policy Holder's DOB: _____

Policy Holder's Employer: _____ Relationship to Patient: _____

Primary Care Physician: _____ PCP Phone: (_____)_____

Preferred Pharmacy: _____ Pharmacy Phone: _____

AUTHORIZATION

I certify that the above information is true and accurate. I authorize the release of any medical or other information necessary to process a claim or continue medical treatment. I also authorize payment of medical benefits paid directly to **Modern Endocrine**. I acknowledge that I am responsible for payment if my insurance company denies my claim.

_____ _____

Patient Signature Date

_____ _____

Parent or Legal Guardian Signature (If patient is a minor) Date