Patient Registration

FULL CIRCLE
ENDOCRINOLOGY

Date _____

Patient Information

Patient Name _____ Age _____ Date of Birth _____

Patient Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Cell Phone _____ Work Phone _____

Last 4 Digits of Your Social Security Number _____ Email _____

Marital Status (Indicate Single, Married, Partnered, Divorced, Widowed, etc.) _____

Sex (Male or Female) _____

Information Sharing

May we leave you a voicemail regarding your medical condition/labs? Yes/No _____ Phone _____

May we discuss your medical condition with members of your family or others you identify? Yes/No _____

Name _____ Phone _____

Employment & Emergency Contact Information

Patient's Employer _____ Patient's Occupation _____

Spouse's Name _____ Spouse's Employer _____

Spouse's Occupation _____ Spouse's Employer Phone _____

Emergency Contact (Not at the Same Address) _____

Phone _____

Physician Information

Family Physician _____

Phone _____ Fax _____

Referring Physician _____

Phone _____ Fax _____

Patient Registration (continued)

Insurance Information

Primary Insurance Company _____

Name of Cardholder_____ ID # _____

Policy/Group# _____ Date of Birth of Cardholder _____

Last 4 Digits of Cardholder's SSN # _____

Secondary Insurance Company _____

Name of Cardholder _____ ID # _____

Policy/Group# _____ Date of Birth of Cardholder _____

Last 4 Digits of Cardholder's SSN # _____

Complete This Section if the Patient is a Minor or Full Time Student

Student Status (Full Time or Part Time) _____

Father's Name _____ Last 4 Digits of SSN#_____ Date of Birth _____

Employer _____ Work Phone _____

Mother's Name _____ Last 4 Digits of SSN#_____ Date of Birth _____

Employer _____ Work Phone _____

IMPORTANT

I authorize Dr. Navtika Desai and Full Circle Endocrinology to furnish information to insurance carriers concerning my illness and treatments and hereby assign them all payments for services rendered to me or my dependents. I understand that I am responsible for amounts not covered by my insurance.

SIGN HERE _____
Signature of Patient or Legal Representative

_____
Date

If legal representative, please indicate relationship to patient _____

Patient Information Release Form

FULL CIRCLE
ENDOCRINOLOGY

Authorization to Release Healthcare Information

Patient's Name _____ Date of Birth _____

Previous Name _____

I request and authorize to release health care information of the patient named above to:

Full Circle Endocrinology
Navtika R. Desai, DO
105 Raider Boulevard Suite 200
Hillsborough, NJ 08844
P 908 829 4244
F 908 382 3280

This Request and Authorization Applies to:

_____ All healthcare information

Other _____

I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization.

_____
Signature of Patient or Legal Representative

_____
Date

IMPORTANT
(Please list all your current specialty physicians and phone numbers)

Primary/Referring Doctor _____

Prior Endocrinologist _____

Ophthalmologist (Eye) _____

Nephrologist (Kidney) _____

Podiatrist (Feet) _____

Other _____

If legal representative, please indicate relationship to patient _____

This authorization expires five years after it is signed. Please fax records to 908 382 3280.

Notice Of Privacy Practices Summary

FULL CIRCLE
ENDOCRINOLOGY

This is a summary of the Notice of Privacy Practices, which describes how we may disclose your medical and personal information and how you can have access to this information. You will find the full version of our Notice of Privacy in our waiting room, as well as on our website, for your review. Also, we will gladly provide you a personal copy upon request.

Our Pledge to Protect your Privacy

We are committed to protecting the privacy of your medical and personal information. So we can best meet your medical needs, we share your medical records with the health care providers and insurance companies involved in your care. We share your information only to the extent necessary to collect payment for the services we provide, to conduct our business operations, and to comply with the laws that govern health care. We will not use or disclose your health information for any other purpose without your permission.

Your Rights Regarding your Medical Information

– To inspect and obtain a copy of your medical records with certain limitations.

– To request an amendment or addendum to your medical record.

– To an accounting of disclosures of your medical information.

– To request restrictions on certain uses and disclosures of your medical information.

– To request when and where to contact you.

– To request a copy of the full version of this document our Privacy Practices.

We may use and disclose your personal and health information without your authorization for the following purposes

– To provide you with medical treatment.

– To bill and receive payment for the treatment received.

– As required and permitted by law.

– For functions necessary to assure that our patients receive quality care.

– For public health activities (e.g. reporting abuse).

– For research purposes in limited circumstances.

– To the coroner, medical examiner, funeral director or organ procurement organization for certain purposes.

– To a court or administrative order, subpoena, discovery request or other lawful process.

– To a health oversight agency, such as the Department of Health Services.

We reserve the right to change our privacy practices and update this notice accordingly. I have read and understood my rights and Full Circle Endocrinology's Privacy Standards.

_____

Signature of Patient or Legal Representative

_____

Date

If legal representative, please indicate relationship to patient _____

Medication List

FULL CIRCLE
ENDOCRINOLOGY

Patient's Name _____ Date of Birth _____

Allergies _____

Primary Physician (name/phone) _____

Pharmacy (name/city/phone) _____

Medication	Dose	Frequency	Start Date	End Date

Payment Responsibility

FULL CIRCLE
ENDOCRINOLOGY

Acknowledgement of Responsibility for Payment of Service

I, _____ , understand and agree to the following:

My health coverage involves an arrangement between my health plan an myself. Dr. Desai's office staff will submit payment claims to my insurance company or they will do what they can to prepare necessary reports and forms to assist me in collecting appropriate reimbursement from my health care plan. I understand that I am responsible for any unpaid balances and that co-payment is due at time of service.

All of my questions have been answered and I feel comfortable with this professional and financial relationship.

_____
Signature of Patient or Legal Representative

_____
Date

If legal representative, please indicate relationship to patient

Patient History

FULL CIRCLE
ENDOCRINOLOGY

Patient Name _____ Date of Birth_____

Reason for Visit _____

PLEASE COMPLETE ONLY THE SECTION THAT PERTAINS TO YOUR VISIT

Section 1: Thyroid

- ☐ Anxiety or depression
- ☐ Constipation/diarrhea
- ☐ Fatigue
- ☐ Heat/cold intolerance
- ☐ Milk discharge from breast
- ☐ Sore throat
- ☐ Swelling of leg
- ☐ Vision change
- ☐ Brittle nails
- ☐ Clearing throat frequently
- ☐ Hair loss
- ☐ Hoarseness
- ☐ Pain over thyroid
- ☐ Sweating
- ☐ Tingling around mouth/hands
- ☐ Weight gain/loss
- ☐ Coarse hair
- ☐ Difficulty concentrating
- ☐ Headache
- ☐ Irregular periods
- ☐ Palpitations
- ☐ Swelling of eye or eye lid
- ☐ Tremors
- ☐ Other _____

Are you currently pregnant? Yes/No _____Thyroid issues during prior pregnancies? Yes/No _____

Section 2: Thyroid Nodule

- ☐ Cough
- ☐ Hoarseness
- ☐ Pressure over neck
- ☐ Prior radiation exposure to head/neck
- ☐ Family history of thyroid cancer
- ☐ Current or former smoker
- ☐ Neck mass/nodule
- ☐ Shortness of breath
- ☐ If yes, Date _____ Reason _____
- ☐ Other _____
- ☐ Difficulty swallowing
- ☐ Neck pain or tenderness
- ☐ Sore throat

Please document any tests or treatments that you have previously experienced, then provide as much detail as possible so we can obtain your records. If you are unsure of an answer, please leave blank.

- ☐ Ultrasound of thyroid _____
- ☐ Thyroid scan and uptake (this is a nuclear medicine test) _____
- ☐ Thyroid nodule biopsy (US-guided FNA)_____
- ☐ Thyroid surgery (removal of half or all of your thyroid) _____
- ☐ Thyrogen whole body scan (for thyroid cancer patients) _____
- ☐ Radioactive Iodine treatment either for thyroid cancer or overactive thyroid/Graves' _____

Patient History (continued)

Patient Name _____ Date of Birth_____

Section 3: Diabetes

At what age were you diagnosed? _____

☐ Blurred vision ☐ Headache ☐ History of diabetes during pregnancy

☐ Increased thirst ☐ Tingling/numbness of hands/feet ☐ Urinating frequently

How often do you check your blood sugars? _____ Glucometer make/model _____

Most recent eye doctor appointment _____ How often do you exercise? _____

Current/Prior foot ulcers? Yes/No_____ Podiatrist's name _____

Current/Prior kidney problems? Yes/No_____ Nephrologist's name _____

Current/Prior heart problems? Yes/No_____ Cardiologist's name _____

Section 4: Polycystic Ovarian Syndrome (PCOS)

At what age did you have your first period? _____ Was your period regular or irregular? _____

☐ Acne ☐ Facial hair or hair on belly ☐ History of infertility ☐ Family history of PCOS

Did you have Diabetes during any of your pregnancies? Yes/No _____

Section 5: Osteoporosis

Prior bone density test? Yes/No _____ Prior fracture? Yes/No_____ Year _____

Family history of osteoporosis? Yes/No _____ Family history of hip fracture? Yes/No _____

Have you lost height? Yes/No _____How many inches? _____

Have you had kidney stones? Yes/No_____ Are you menopausal? Yes/No _____

Have you had prior radiation treatment for any cancer? Yes/No_____ For what? _____

IMPORTANT – ALL PATIENTS MUST COMPLETE THIS SECTION

Medical History

Please list all of your current and past medical problems and when each was diagnosed:

_____ Diagnosis year _____

_____ Diagnosis year _____

_____ Diagnosis year _____

_____ Diagnosis year _____

_____ Diagnosis year _____

Please list all surgeries you have had and when you had them:

_____

_____

Social History

Check all that apply: ☐ Married ☐ Single ☐ Divorced ☐ Partner ☐ Widow # of Children _____

Occupation _____ Religion _____ Language _____ Ethnicity_____

Do you currently smoke? Yes/No _____ If you quit, when did you quit? _____

How many years did you smoke? _____ How much did you smoke? _____

How often do you drink alcohol?_____

Family History (Please check Alive or Deceased and document cause of death and/or all medical problems)

Mother: ☐ Alive ☐ Deceased _____

Father: ☐ Alive ☐ Deceased _____

Siblings: ☐ Alive ☐ Deceased _____

Grandparents: ☐ Alive ☐ Deceased _____