



Dr. Shahid Aziz M.D. / Dr. Dina Rivera M.D.

Patient Registration Form

Whom may we thank for your referral? _____

Phone _____

Other _____

PCP _____

Patient Information

Patient Name _____ DOB ___/___/___ Age _____ Sex F M (circle)

Phone _____ Cell _____ SSN ___-___-___ Marital Status _____

Address _____ City _____ State _____ Zip _____

Employer Name _____ Phone _____

Emergency Contact _____ Phone _____

EMAIL: _____ Preferred Language: _____

Ethnicity: Hispanic or Latino Other

Student Status: Full Time Part Time

Race: American Indian or Alaska Native Asian

Black or African American

Native Hawaiian or Pacific Islander White

Other

Primary Insurance Information

Primary Insurance Name _____

Name of insured _____ Phone _____ DOB ___/___/___

SSN ___-___-___ Insurance ID Number _____ Group Number _____

Address _____ City _____ State _____ Zip _____

Relationship to patient _____

Secondary Insurance Information

Secondary Insurance Name _____

Name of insured _____ Phone _____ DOB ___/___/___

SSN ___-___-___ Insurance ID Number _____ Group Number _____

Address _____ City _____ State _____ Zip _____

Relationship to patient _____

Reviewed by

Date

Patient #/ Doctor #

San Antonio Endocrinology & Diabetes Care

Terms of Agreement

Please INITIAL after each term of agreement

- **San Antonio Endocrinology & Diabetes Care** has the right to release confidential medical information to other parties involved in my care including my insurance carrier, my referring physician and/or my primary physician.

- If my insurance requires a referral and I do not obtain one in advance of my appointment, I will be required to make payment in full or reschedule my appointment. _____

- I understand and agree that I am financially responsible for all in-network and/or out-of-network balances owed to **San Antonio Endocrinology & Diabetes Care** as assigned by my insurance carrier. _____

Acknowledge Of Receipt of Notice of Privacy Practices

I acknowledge that I have been given an opportunity to review the Notice of Privacy Practices from **San Antonio Endocrinology & Diabetes Care** and that I may request a copy for my records if I so choose.

Signature of Patient or Legal Representative

Date

Print Name of Patient or Legal Representative

Date

Acknowledgement and Authorization to Treat

I hereby acknowledge the information given is true to the best of my knowledge and I understand the terms and agreements made with **San Antonio Endocrinology & Diabetes Care**.

I, _____ Legal Guardian/Parent/Self, authorize medical treatment by a staff physician associated with, **San Antonio Endocrinology & Diabetes Care**.

Patient or Legal Representative Signature

Date ____/____/____

Responsible Party Name _____ DOB ____/____/____ SS# _____-_____-_____

Reviewed by

Date

Patient #/ Doctor #

San Antonio Endocrinology & Diabetes Care

Shahid Aziz, MD

Initial Patient Visit Form

Date _____

Name: First _____ M.I. _____ Last _____

For Minor Children:

Mother's Name _____

Father's Name _____

What problem are you seeing the doctor for? _____

Hand Dominance _____ Right _____ Left _____ Both/Ambidextrous

Have you had any previous treatment for this condition? Yes No If yes, what doctor did you see and when?

Medications:

Please list your Pharmacy information and all medications, including doses (if known) that you are currently taking. Include over the counter drugs, herbs, vitamins, etc.

Pharmacy	Address	Phone Number
Medication	Dose	Frequency
Allergies**Please list <u>all</u> allergies: include medications, foods (shellfish, nuts, etc), materials (tape and latex products, etc) and other substances. If none, please write "None".	Reaction	

San Antonio Endocrinology & Diabetes Care
Review of Systems Pertaining to the Patient

Patient #/ Doctor #

BP: ____/____

HT: _____

WT: _____

For Office Use Only

Have *you* had or are *you* currently having problems with any of the following?
 Please mark with a ✓ yes or no and describe all YES responses.

Problems	Yes	No	Description
Blackouts/fainting			
Bleeding/Clotting			
Blood Transfusions			
Bone/ Muscle			
Cancer			
Colon			
Diabetes			
Digestion/GI			
Ears, nose, throat			
Epilepsy/Seizures			
Eyes			
Fever, Chills, Night sweats			
Hay fever/Allergies			
Heart: chest pain, irregular rhythms, palpitations, etc.			
Hepatitis A, B, C			
High blood pressure/Hypertension			
High Cholesterol			
HIV			
Kidney/Bladder			
Loss of balance/dizziness			
Low blood pressure			
Lung, Breathing			
Neuropathy			

Numbness/Tingling			
Polio			
Prostate enlargement			
Psychological			
Seizures			
Skin/Breast			
Thyroid			
Other:			

I understand that any person who knowingly and with intent to defraud any insurance company or other persons, files a statement of claim containing any materially false information or who conceals, for the purpose of misleading, information concerning any fact, commits a fraudulent act, which is a crime subject to criminal prosecution and civil penalties.

Signature of patient, parent or guardian (if minor) Date Chart #

For Office use only:

Physician	Date	Physician	Date	Physician	Date