



Dr. Shahid Aziz
Dr. Gabriela Mroueh
Dr. Dina Rivera

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 _____ Marital Status _____

Address _____ City _____ State _____ Zip _____

Employer Name _____ Phone _____

Emergency Contact _____ Phone _____

EMAIL: _____ Preferred Language: _____

Ethnicity: Hispanic or Latino Other

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 ____/____/____

Insurance ID Number _____ Group Number _____

Secondary Insurance Information

Secondary Insurance Name _____

Name of insured _____ Phone _____ DOB ____/____/____

Insurance ID Number _____ Group Number _____

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. _____

There will be a \$25 no-show fee for missed appointments. We understand that situations arise which require you to cancel your appointment. We request you to call at least 24 hours prior if you can not attend. If you call the day of your appointment or within the 24 hour time period before your appointment you will be charged a \$25.

New patients \$50. _____

- 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 ____/____/____

What problem are you seeing the doctor for? _____

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

Social History:

Do you drink alcohol?

- Yes, Rarely (< 1/month) Occasionally (1-4/month) Socially (1-2/week)
 Frequently (3-5/week) Daily
- No, Used to but stopped (date) _____ Never used alcohol

How often do you exercise?

- Never Rarely (< 1/month) Occasionally (1-4/month) Frequently (3-5/week) Daily

Do you smoke tobacco products? (Required for all patients 13 years and older)

- Yes, I currently smoke. I smoke _____ packs per day and have smoked for _____ years.
 No, but I used to smoke. I smoked _____ packs per day for _____ years and quit _____.
 No, I have never smoked

Do you have a Special Diet? No Yes (describe) _____

Do you use controlled or illegal substances?

- Yes, Rarely (< 1/month) Occasionally (1-4/month) Socially (1-2/week)
 Frequently (3-5/week) Daily
- No, Used to but stopped (date) _____ Never used drugs
- Which drugs do/did you use? Cocaine Marijuana other _____

Family history:

Has anyone in your immediate family ever had any of the following? (Mark all that apply)

Please specify who the history applies to: Mother, father, sister, brother, grandmother, or grandfather.

- | | | |
|---|--|---|
| <input type="checkbox"/> None known | <input type="checkbox"/> colitis | <input type="checkbox"/> leukemia |
| <input type="checkbox"/> alcoholism | <input type="checkbox"/> coronary artery disease | <input type="checkbox"/> rheumatic Fever |
| <input type="checkbox"/> anxiety/depression | <input type="checkbox"/> diabetes | <input type="checkbox"/> seizure disorder |
| <input type="checkbox"/> asthma | <input type="checkbox"/> high blood pressure | <input type="checkbox"/> stroke |
| <input type="checkbox"/> bleeding/clotting problems | <input type="checkbox"/> high Cholesterol | <input type="checkbox"/> tuberculosis |
| <input type="checkbox"/> cancer | <input type="checkbox"/> hypothyroidism | <input type="checkbox"/> other _____ |

Serious Illnesses and Hospitalizations:

Please list all serious illnesses and/or hospitalizations along with any complications:

Illness or Reason for Hospitalization	Year	Complications? (describe)

Operations:

Please list all previous operations along with any complications:

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



San Antonio
Endocrinology & Diabetes Care
saendocrine.com

11212 State Hwy 151, Ste 180 San Antonio, TX 78251, P: 210-352-5006 F: 210-352-5016

Patient Name _____ Date of Birth _____

Previous Name _____

I request and authorize _____ to release
healthcare information of the patient named above to:

San Antonio Endocrinology & Diabetes Care

11212 State Hwy 151 Suite 180

San Antonio, TX 78251

This request applies to:

- Healthcare information relating to the following treatment, condition, or date: _____

- All health-related information _____

- Other: _____

- Patient Signature: _____ Date: _____