San Antonio Endocrinology & Diabetes Care
saendocrine.com

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 $50 no-show fee for established patients who miss 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 $50. New patients $100. _____

- Any administration paperwork that needs processed such as (FMLA) there will be a $50 fee.

- 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***.

_____Date_____/_____/_____
Patient or Legal Representative Signature

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 all 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.

□ None known	□ colitis	□ leukemia
□ alcoholism	□ coronary artery disease	□ rheumatic Fever
□ anxiety/depression	□ diabetes	□ seizure disorder
□ asthma	□ high blood pressure	□ stroke
□ bleeding/clotting problems	□ high Cholesterol	□ tuberculosis
□ cancer	□ hypothyroidism	□ 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:

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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:_____