Date: _____ Karassi Endocrinology MRN #: _____

PATIENT INFORMATION SHEET

Patient Name: (Last)_____ (First) _____ (Mi) _____

DOB: _____ SSN: _____-_____-_____ Home Phone: _____ Work phone: _____ Cell phone: _____ Personal Email: _____ Sex: _____

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

Marital Status: Single Married Divorced Widowed

Employment: Employed Student Retired Employer: _____ Phone: _____

Person Responsible for Acct: _____ Relationship: _____ Phone: _____

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

Person to notify in case of emergency: _____ Relationship: _____ Phone: _____

Have you arranged for a Living Will? YES NO **Have you appointed a Durable Power of Attorney?** YES NO

INSURANCE POLICY INFORMATION

Primary Insurance: _____ Policy Holders Name: _____ DOB: _____

Contract #: _____ Group #: _____ Referral Required: YES NO

Secondary Insurance: _____ Policy Holders Name: _____ DOB: _____

Contract #: _____ Group #: _____ Referral Required:

PHARMACY INFORMATION

Pharmacy Name: _____ Phone #: _____

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

CONSENT FOR TREATMENT

I consent to necessary treatment, including drugs, medicine, performance of operations and conduct of X-Ray, or other studies that may be used by the attending physician, his nurse, or staff. Authorization for Release of Information: I authorize Karassi Endocrinology and Internal Medicine P.C. to furnish any medical information requested by insurance companies with whom I have coverage, any public agency which may be assisting in payment of my care, or my employer who is providing payment of my medical bills due to an on the job injury. Assignment of Benefits: I hereby authorize payment directly to Karassi Endocrinology & Internal Medicine P.C. of benefits otherwise payable to me including major medical insurance and payment of medical benefits, but not to exceed the Karassi Endocrinology & Internal Medicine P.C. for charges not covered by this assignment. I authorize the refund of overpaid insurance benefits where my coverage is subject to coordination of benefits. Guarantee of Account: For services furnished by Karassi Endocrinology & Internal Medicine P.C., I hereby guarantee the payment of all accounts for services rendered. For payment of said account for services, I hereby waive all claims of exemption under the State of Alabama and agree to pay, if necessary all costs of collection, including attorney fees. I have been offered to review the HIPAA Notice of Privacy Practices.

Signature of Patient: _____ Date: _____

MRN #: _____

ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES
ALTERNATIVE PEOPLE AND COMMUNICATION AUTHORIZATION FORM

When it comes to your medical treatment, we strive to communicate with you in a timely and professional manner. However, there are certain occasions when family members, friends and others might be involved in your case as a patient and you will want our office to be able to communicate directly with them. In order to protect the privacy of your personal health information, please share with us the names of any other people with whom we may discuss your care and share your protected information.

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Patient Signature: _____ Date: _____

TEXT REMINDER / Patient Portal CONSENT FORM

Our clinic uses an automated text reminder system and patient portal. Text reminders will be for your appointments and billing balances. Patient Portal is an easier way to communicate with the office via messages directly to the clinic staff. This results in quicker response times and the ability to receive lab results and correspondence concerning your care directly from our Providers.

Email: _____ Cell Phone #: _____

Carrier: ____ AT&T ____ T-Mobile ____ Verizon ____ Other: _____

Consent to Text Message appointment reminders and Patient Portal

Please initial next to the following which applies:

_____ I DO consent to the use of automated messaging reminders and the use of the patient portal.

_____ I DO NOT consent to the use of automated messaging reminders or the patient portal.

MRN #: _____

MEDICAL HISTORY:

Reason for today's visit (Please indicate your major concern(s)):

_____

_____

_____

Previous Serious Illness(es):

Year of Onset:	Illness:	Condition at Present:

Recent or Serious Surgeries or Procedures:

Year of Onset:	Procedure:	Condition at Present:

Do any of the following diseases run in your family?

Diabetes _____ Thyroid _____ Parathyroid _____ Pituitary _____ Adrenal _____ Testicular/Ovarian _____

MRN #: _____

PERSON SOCIAL HISTORY (Circle and fill in blanks):

Occupation: _____

Alcohol: Non-Drinker Rarely Socially Daily

Consumption per week: Beer _____ Wine _____ Liquor _____

Tobacco: Never

Current Smoker → Age you began smoking: _____ Number of packs/day: _____

Quit Smoking → How many years did you smoke: _____ Year quit smoking: _____

Recreational Drug Use: Yes No

Recreational Activities (what do you do in your spare time?) _____

Do you exercise? Yes No How often? _____

If yes, what type? _____

MRN #: _____

GENERAL		ENDOCRINE		SKIN	
Weight Loss		Heat Intolerance		Rash	
Excessive Weigh Gain		Cold Intolerance		Change in Color	
Decreased Appetite		Breast Changes		Acne	
Increased Appetite		Extreme Thirst		Hair Growth	
Fatigue		Low Blood Glucose		Hair Loss	
Fever		Hypoglycemic Unawareness		Itching / Dryness	
Excessive Sweating		Increased Urination		Nail Issues	
Dizziness		Thyroid Disease		Foot Wound	
		Diabetes		Prolonged Bleeding	
		Pancreatitis			
HENT / NECK		**EYES**		**CARDIOVASCULAR**	
Nose Bleeds		Blurred Vision		Chest Pain	
Sore Throat		Bleeding in Eyes		Tightness in Chest	
Chronic Headaches		Glaucoma		Racing Heart Rate	
Neck Pain		Bulging		Slow Heart Rate	
Trouble Swallowing		Dryness		Pounding Heart	
Change in Voice		Eye Pain		Shortness of Breath	
Swollen Lymph Nodes		Glasses		Swelling in Feet / Legs	
Painful Lymph Nodes		Contacts		Leg Pain when Walking	
Hearing Changes		Vision Changes		Fainting	
Hearing Loss		Last Eye Exam		History of Heart Attack	
GENITOUTARY		**NEUROLOGICAL**		**GASTROINTESTINAL**	
Frequent UTI		Seizures		Diarrhea	
Frequent Yeast Infection		Headaches / Migraines		Vomiting / Nausea	
Awakening at Night		Pain / Burning in Legs / Feet		Abdominal Pain	
Kidney Stones		Muscle Weakness		Fullness / Bloating	
Kidney Disease		Anxiety		Heartburn	
Blood in Urine		Depression		Bloody / Black Stool	
				Constipation	

FOR WOMEN ONLY		
Ovarian Cyst? YES NO	Age of First Period:	Date of Last Period:
Periods: Regular / Irregular	Period Typically Lasts:	Spotting Between Periods? YES NO
Number of Pregnancies:	Number of Live Births:	Menopause? YES NO
Age of Menopause:	Age of Hysterectomy:	Hormone Treatment? YES NO
Heavy Periods? YES NO	Birth Control? YES NO	Type of Birth Control: