P▯▯ENT REGISTRATION ▯▯RM

DATE

PATIENT ACCOUNT NUMBER

PRACTICE NAME

NEOE

PATIENT INFORMATION *(Please write information about the patient here.)*

PATIENT'S NAME (Last, First, Middle Initial) — SEX ☐ Male ☐ Female

PATIENT'S ADDRESS

CITY — STATE — ZIP

TELEPHONE ( ) — MARITAL STATUS ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed — DATE OF BIRTH ___/___/___ MO DAY YR

AGE — SOCIAL SECURITY NUMBER

PATIENT INFORMATION

REFERRING DOCTOR

REFERRING DOCTOR ADDRESS — CITY — STATE — ZIP

EMPLOYER'S NAME — TELEPHONE ( )

EMPLOYER'S ADDRESS — CITY — STATE — ZIP

EMPLOYMENT STATUS ☐-Full Time ☐-Retired ☐-Part time ☐-Not Employed

STUDENT STATUS: If 19 Years or older: ☐-Full Time ☐-Part Time ☐-Not a Student

INSURANCE INFORMATION *(Please write information about the patient's insurance here.)*

PRIMARY INSURANCE COMPANY NAME

INSURANCE COMPANY'S ADDRESS

CITY — STATE — ZIP

INSURED'S ID NUMBER — GROUP PLAN NUMBER

SECONDARY INSURANCE COMPANY NAME

INSURANCE COMPANY'S ADDRESS

CITY — STATE — ZIP

INSURED'S ID NUMBER — GROUP PLAN NUMBER

POLICYHOLDER INFORMATION

(Complete the information below if the PATIENT is NOT the POLICYHOLDER)

PRIMARY POLICYHOLDER'S NAME (Last, First, Middle Initial) — DATE OF BIRTH ___/___/___ MO DAY YR

PRIMARY POLICYHOLDER'S ADDRESS — SEX ☐ Male ☐ Female

CITY — STATE — ZIP — TELEPHONE ( )

EMPLOYER'S NAME OR SCHOOL NAME — TELEPHONE ( )

EMPLOYER'S ADDRESS

CITY — STATE — ZIP

SOCIAL SECURITY NUMBER — RELATIONSHIP TO PATIENT ☐ SPOUSE ☐ PARENT ______ OTHER

EMPLOYER PLAN COVERAGE ☐ YES ☐ NO — IF CHAMPUS: ☐ Active ☐ Retired ☐ Deceased — Branch of Service: ______

Is the secondary policyholder the: ☐*Patient* ☐*Primary Policyholder* ☐*Othe*

(Complete the information below if you checked "Other")

SECONDARY POLICYHOLDER'S NAME (Last, First, Middle Initial) — DATE OF BIRTH ___/___/___ MO DAY YR

SECONDARY POLICYHOLDER'S ADDRESS — SEX ☐ Male ☐ Female

CITY — STATE — ZIP — TELEPHONE ( )

EMPLOYER'S NAME OR SCHOOL NAME — TELEPHONE ( )

EMPLOYER'S ADDRESS

CITY — STATE — ZIP

SOCIAL SECURITY NUMBER — RELATIONSHIP TO PATIENT ☐ SPOUSE ☐ PARENT ______ OTHER

EMPLOYER PLAN COVERAGE ☐ YES ☐ NO — IF CHAMPUS: ☐ Active ☐ Retired ☐ Deceased — Branch of Service: ______

RESPONSIBLE PARTY INFORMATION

Responsible party is: ☐*Patient* ☐*Primary Policyholder* ☐*Secondary Policyholder*

(Please complete the information below if the person responsible for paying the bill is not the PATIENT or the POLICYHOLDER)

RESPONSIBLE PARTY'S NAME (Last, First, Middle Initial) — SEX ☐ Male ☐ Female

RESPONSIBLE PARTY'S ADDRESS — STATE — ZIP

TELEPHONE ( ) — RELATIONSHIP TO PATIENT ☐ SPOUSE ☐ PARENT ☐ GUARDIAN ______ OTHER

DATE OF BIRTH

SOCIAL SECURITY NO. — DRIVER'S LICENSE NO. — LEGAL REPRESENTATIVE ☐ Yes ☐ No

EMPLOYER'S NAME — TELEPHONE ( )

EMPLOYER'S ADDRESS — STATE — ZIP

I AGREE TO THE ASSIGNMENTS AND FINANCIAL RESPONSIBILITIES SHOWN ON THE BACK OF THIS FORM. YOU SHOULD READ THOSE TERMS CAREFULLY.

X ______________________________ **Date** ________

SIGNED (Patient, or parent if under 18 years of age.)

HOW DID YOU HEAR ABOUT US? ______________________________

____

IN CASE OF AN EMERGENCY

– WHO SHOULD WE CONTACT? –

(Please list someone not living at your residence — other than those listed on the reverse side. Neighbor, friend, relative, etc.)

NAME ______________________ TELEPHONE: Day - (   ) ________

ADDRESS ______________________ Night - (   ) ________

CITY ____________ STATE ____________ RELATIONSHIP ________

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance.

IN ORDER TO CONTROL YOUR COST OF BILLINGS, WE REQUEST THAT OUR CHARGES FOR OFFICE VISITS BE PAID AT THE CONCLUSION OF EACH VISIT.

If this account is assigned to an attorney for collection and/or suit, the practice shall be entitled to reasonable attorney's fees and costs of collection.

I authorize the release of any information necessary to determine liability for payment and to obtain reimbursement on any claim.

I request that payment of authorized benefits be made on my behalf. I assign the benefits payable to which I am entitled including Medicare, private insurance and other health plans to the practice named on the other side of this form.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance.

THANK YOU FOR YOUR COOPERATION

Notice to our patients:

Please email or call our office during business hours to cancel your appointment.

We require a 48 hour notice.

You will be billed $40.00 if appointments are not cancelled in the requested time.

Thank you,

Northeast Ohio Endocrinology

Signed ______________________

Date ______________________

NEOE

NorthEast Ohio Endocrinology and Osteoporosis Institute

Welcome. To assist us with completing your evaluation, please answer the following questions. Thank you.

Name. ____________________ Date. __________

Age. ____________________

Sex. ____________________

Ethnic background. ____________________

Family History of Osteoporosis, Thyroid Disease, Diabetes, Cancer, Heart Disease, or other illness (Who and at what age).

____

____

Tobacco/cigarette use (type and how long). ____________________

Caffeine use (approximate amount per day). ____________________

Alcohol use. ____________________

Dairy/calcium intake (amount per day). ____________________

Past medical history. ____________________

____

Past surgical history. ____________________

____

Immobilization (ie. extended bed rest, lengthy casting, routine inactivity). List type and for how long.

____

____

Please continue on other side

List any fractures (broken bones), which bone fractured, when, and cause of fracture.

____

____

Physical activity/exercise. List type and how often.______________________________

____

Allergies. ____

____

Medications.____

____

____

Also please circle any of the following which apply to you (past or present).

Anemia
Anorexia/Eating disorder
Black stools
Cancer (type)________

Chicken Pox
Measles
Mumps
Small Pox
Crohn's Disease

Cystic Fibrosis
Diabetes (how long)______
Epilepsy
Gall Bladder Disease

Heart Disease
Hepatitis
High Blood Pressure

Hypogonadism(low male hormone)
Jaundice
Liver failure

Malabsorption /multiple stools (greater than 3 times per day)
Mastocytosis(skin reaction)

Multiple Myeloma
Palpitations(heart racing)

Pneumonia
Rheumatic Fever
Scarlet Fever
Seizure disorder

Steroid (prednisone/medrol) use (type and how long)______________________________

Thyroid Disease type______________
Goiter
Cushings Disease

Tuberculosis
Typhoid Fever
Whooping Cough
Ulcerative Colitis

Menopause age ________
No menstral periods