PLEASE PRINT CLEARLY

PATIENT REGISTRATION FORM

Please provide your insurance card and picture ID to the receptionist

Today's Date:

Primary Provider: Pharmacy Name/Phone # PBM Yes/No

PATIENT DEMOGRAPHIC INFORMATION

Last Name: First Name: Middle:

Preferred Name: Maiden Name: Prefix (circle one) Miss Mr. Mrs. Ms. Suffix (circle one) N/A I II III IV Jr. Sr.

Date of Birth: Sex: Social Security #: Race:

Marital Status: Drivers License # Primary Language:

Religion: Ethnicity: (Circle One) Decline Hispanic/Latino Not Hispanic/Latino Unknown

Address:

Zip: City: State: County:

Home Phone: Work Phone: Cell Phone: Primary Number:

Is it ok to leave a message at HOME Y____N_____ WORK Y____N_____ CELL Y____N____

Fax #: Email address:

Preferred Communication: (circle one) Home Cell Work Mail Other

Employer: Occupation: Phone #:

ASSOCIATED PARTY/EMERGENCY CONTACT

Last Name: First Name: Date of Birth

Address: City: State: Zip:

Home Phone #:______________________________ Alt. Phone #: ________________________ Relationship to Patient ___________

Send Statement To: ____ (if different from patient)

INSURANCE INFORMATION

Primary Insurance:	Secondary Insurance:
Member's ID #: Group #	Member's ID #: Group #
Name of Policy Holder:	Name of Policy Holder:
Relationship to Patient:	Relationship to Patient:

If Policy holder is other than patient, please complete following information:

Policy Holders Name: Social Security # Date of Birth

Address: City: State: Zip:

Phone Number: Alt. Phone Number: Employer:

SIGNATURE SECTION

To the best of my knowledge, the information on the registration form is complete and correct. I understand that it is my responsibility to inform my doctor and his staff if there is a change in health, insurance and/or contact information.

Patient Signature:____ Date:_______________

CONSENT TO TREATMENT

I voluntarily consent to medical care at **Consolidated Medical Practices of Memphis** for routine diagnostic examination and medical treatment including, but not limited to, routine laboratory work (such as blood, urine and other studies), taking of x-rays, heart tracing and administration of medications prescribed by the physician.

I further consent to the performance of those diagnostic procedures, examinations and rendering of medical treatment by the medical staff and their assistants, including nurse practitioners, physician's assistance, medical assistants, or their designees as necessary in the medical staff's judgment. This consent is valid and remains in effect as long as I receive medical care at **Consolidated Medical Practices of Memphis**

I promise as a patient of **Consolidated Medical Practices of Memphis** to I will follow all office policy that pertain to the patients of the office. I understand that if I am not compliant with following the physicians' plan of care, I can be terminated from the practice. By signing this I agree to follow the plan of care to the best of my ability.

Patient Signature:____ Date: _______________

PRIVACY STATEMENT

We consider any information that concerns your health, health care, or payment for that care to be confidential and protected information. This notice describes our privacy practices, specifically how we use and disclose your medical information and what rights you have with respect to this information. This information includes your name, address, and other identifying data, and information on your health or the health services that have been or may be furnished to you. We require all of our employees, staff, volunteers, and independent contactors to comply with these privacy practices. We are required by federal law to obtain an acknowledgment from you that you received this notice.

Patient Signature:____ Date: _______________

BENEFIT AUTHORIZATION

(a) I authorize **Consolidated Medical Practices of Memphis** to release medical information to third party insurance carriers for the purpose of filing insurance claims related to my medical care.
(b) I also request that payments of authorized benefits be made to me or on my behalf to **Consolidated Medical Practices of Memphis** for services rendered.
(c) I further authorize the release of medical information about treatment here to my doctor or anyone designated byme.
(d) I authorize the use of my signature on all insurance submissions.
(e) I understand I am responsible for payment of all medical expenses incurred due to services rendered at the time ofservice.
(f) I agree to provide complete and accurate information about all insurance policies that I participate in and advise the doctor and staff of any changes.

Patient Signature:____ Date: _______________

RELEASE OF INFORMATION DESIGNATION

I authorize physicians and staff of **Consolidated Medical Practices of Memphis** to speak with the following people regarding insurance and billing concerns.
Name:______________________________ Phone #:______________________ Relationship:________________

I authorize physicians and staff of **Consolidated Medical Practices of Memphis** to speak with the following people regarding my health care, plan of treatment, medications, and lab/test results.
Name:______________________________ Phone #:______________________ Relationship:________________

ACCOUNT COLLECTIONS AGREEMENT

In the event that your account is placed with a Collection Agency, a collection-fee of up to 33.3% may be added to your account and shall become a part of the Total Amount Due. In the event your account is placed with an Attorney, you will be responsible for the reasonable Attorney fees and court cost.

You agree, that in order for us to service your account or to collect any amounts you may owe we and our collection agencies may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We and our collection agencies may also contact you by sending text messages or emails, using any email address you provide to use. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

Patient Signature: ____ Date: _________________

Endocrinology Medical History Form

Name: ______________________ Date of birth: __________ Today's date: _________

Current medications:

Drug Name	Dosage (mg, mcg, etc,)	Frequency	Start Date

Allergies: *(List all known allergies (drug, food, etc.) and reaction)*

- **No known allergies**

_________________________ _____________________________

_________________________ _____________________________

_________________________ _____________________________

Prior surgeries:

Type of surgery/year: _________________________________

_____________________________ ________________________________

_____________________________ ________________________________

Name: ___________________________ Date of birth: ________Today's date: _________

Review of systems: In the last 6 months, have you consistently experienced any of the following symptoms?

Constitutional:			Genitourinary:		
Weight Loss	Y	N	Blood in your urine	Y	N
Weight Gain	Y	N	Menstrual changes	Y	N
Fever	Y	N	Erection problems	Y	N
Fatigue	Y	N	Vaginal discharge or bleeding	Y	N
Eyes:			Musculoskeletal:		
Eye pain or drainage	Y	N	Broken bones	Y	N
Dry, irritated eyes	Y	N	Muscle aches	Y	N
Visual changes	Y	N	Muscle weakness	Y	N
			Neck pain	Y	N
			Joint pain	Y	N
ENT/month:			Skin/breasts:		
Ear pain or drainage	Y	N	Masses or lumps	Y	N
Hearing changes or loss	Y	N	Nipple discharge	Y	N
Nosebleeds	Y	N	Rashes and non-healing ulcers	Y	N
Dizziness	Y	N			
Respiratory:			Neurologic:		
Cough lasting > 1 month	Y	N	Seizures	Y	N
Shortness of breath	Y	N	Coughing/choking with swallowing	Y	N
Wheezing	Y	N	Excessive daytime sleepiness	Y	N
	Y	N	Leg pain or burning sensation	Y	N
			Numbness or tingling	Y	N
			Headache	Y	N
Cardiovascular:			Endocrinologic:		
Chest pain and heaviness	Y	N	Hair loss	Y	N
Palpitations	Y	N	Frequent urination	Y	N
Fainting or near fainting spells	Y	N	Increased thirst	Y	N
Swelling of feet or legs	Y	N	Cold intolerance	Y	N
Shortness of breath lying flat in bed	Y	N	Heat intolerance	Y	N
Gastrointestinal:			Heme/lymph:		
Abdominal pain	Y	N	Unexplained bruising	Y	N
Nausea/vomiting	Y	N	Night sweats	Y	N
Constipation	Y	N	Swollen, painful lymph nodes	Y	N
Diarrhea or food intolerance	Y	N			

Name: ____________________________ Date of birth: ______________ Today's date:______

Medical history:

Problem	Year of Diagnosis	Problem	Year of Diagnosis	Problem	Year of Diagnosis
Diabetes		Hypothyroidism		Low testosterone	
High blood pressure		Hyperthyroidism		Pituitary tumor	
High cholesterol		Thyroid nodule (s)		*Specify type:*	
Heart attack(s)		Thyroid cancer		Other _________	
Stroke		Osteoporosis		Other _________	
Kidney disease		Vitamin D deficiency		Other _________	
Years of dialysis:		High calcium levels		Other _________	
Diabetic eye disease		Adrenal insufficiency		Other _________	
Diabetic neuropathy		Polycystic ovarian		Other _________	

Family member	Good Health	Heart Disease (age of onset)	Hypertension (age of onset)	Stroke (age of onset)	Cancer type (age of onset)	Diabetes (age of onset)
Father						
Mother						
Grandfather (paternal)						
Grandmother (paternal)						
Grandfather (maternal)						
Grandmother (maternal)						
Brother						
Sister						
Other_______________						

Gynecologic history:

Your age during your first menstrual period: ____ Average time between cycles: _____ Average length of each cycle: _____How many pregnancies?_____

Social history:

1. Please briefly describe your occupation: ____

2. Please briefly describe your living situation, i.e. who lives in your house/apartment and relationship to you?
____

3. Tobacco use: Current / Former/Never Cigarettes/Day: ___Years used: ___Year Quit? ___
   If you are currently smoking, are you ready to quit? Yes or No

4. Recreational drug use: Yes or No/ Former/ Type: _______ How often? ______

5. Alcohol use: Yes or No/Former/ Amount: __________ How often? ________

6. Exercise/activity: Yes or No Type: ____________ Frequency/how often?_____ Hours per week: _____

Reviewed by: ____ **Date:** ___________
Provider's signature