ELITE DIABETES & ENDOCRINE SPECIALISTS

2900 N. Military Trail
South Tower, Suite 205
Boca Raton, FL 33431
Elite.endocrine@gmail.com
(561) 235 – 5980 (855) 364 – 4963 fax

Welcome! Please let me know your thoughts about how we treated you beginning with your first phone call to us. Include the waiting room, the staff, phone calls, and any comments you may have.

No Show Policy

In order to provide patients with the time they need, an appointment has been made. This time is reserved time dedicated to one patient. The office cannot function effectively if patients do not show up. Unless there is an unforeseen emergency, please call at least 24h before a scheduled appointment in order to allow us to release that appointment to someone else. A $25 fee for appointments canceled less than 24 hours prior to an appointment or a no show will be implemented.

I have read and agree to the No Show Policy

Signature _____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

By signing this form, you acknowledge that we have provided you with our Notice of Privacy Practices, which explains how your health information may be handled in various situations including your treatment, payment of your bill, and our healthcare operations.

I have received the Notice of Privacy Practices

Patient Name _____

Patient Signature _____ Date _____

CONTACT INFORMATION FORM

Name _____ Marital Status_____

DOB _____ Age _____ Gender _____

Social Security _____

Address _____ Out of State Address_____

_____ _____

PHONES:

Home _____ Cell _____

Fax _____ Work _____

Email _____ Occupation _____

EMERGENCY CONTACT NAME: _____

RELATION: _____ TELEPHONE #:_____

INSURANCE

Please Read and Sign

1. Payment for services is expected at the time of the visit.
2. If insurance is filed, I authorize benefits to be paid directly to Elite Diabetes and Endocrine Specialists.
3. I am responsible for the balance on my account regardless of insurance coverage.
4. I authorize Elite Diabetes and Endocrine Specialists to release information requested with regard to the processing of my claims.
5. I authorize laboratory, test, appointment information, etc. to be left on my home phone answering machine.
6. I authorize laboratory, test, and appointment information to be discussed with my spouse or other family member. I understand a copy of my insurance card will be made.

Patient Name _____ Date _____

Patient's Signature _____

Your Name_____

Reason for today's visit _____

_____

Primary Care Physician _____

Primary Doctor Telephone _____

Other Doctors you see _____

Eye Doctor: _____

How did you hear about us? /**Referred by** _____

ALLERGIES _____

_____

_____

_____

PHARMACY Information

Name of your pharmacy _____

Pharmacy zip code _____

Pharmacy phone# _____

MEDICATION LIST please list here or ask for your list to be copied

_____ _____ _____

_____ _____ _____

_____ _____ _____

Over The Counter Meds: _____

Supplements _____

Vitamins _____

Creams, Lotions, ETC _____

Your Name_____

PAST MEDICAL HISTORY

Diabetes	Thyroid	Kidney	Blood pressure
Eye Problems	Lung	Heart	Cholesterol
Nerve Problems		Cancer	Osteoporosis

Other Past Medical Problems:

Past Surgeries **Date**

FAMILY HISTORY:

Diabetes Thyroid other problems that run in your family

Mother _____

Father _____

Siblings _____

Children _____

Grandchildren _____

SMOKING:

Do you **smoke** now? Yes No

Have you ever smoked? Yes No

How much? _____, how long _____

What have you tried in order to stop smoking?

ELITE DIABETES & ENDOCRINE SPECIALISTS

The **HIPAA** privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of Personal Health Information be made by alternative means, such as sending correspondence to an address other than your home address. The physician and staff of Elite Diabetes & Endocrine Specialists respect your privacy and wish to make all reasonable attempts to respect your wishes regarding your confidential information. With that in mind please indicate your preferences for the areas noted below.

I wish to be contacted in the following manner (check all that apply)

Home/cell telephone

___ Leave a message with detailed information
___ Leave message **only** with call back number

Work Telephone

___ Leave a message with detailed information
___ Leave message **only** with call back number

Written Communications

___ Mail to my home address
___ Fax to this number _____

Other individuals (spouse, family, caretakers, etc. that we may speak with about your care, treatment, lab results, bills, appointments, prescriptions, etc.

NAME RELATIONSHIP

TELEPHONE/CELL #

I understand that I may revoke this authorization at any time with written notification to ELITE DIABETES & ENDOCRINE SPECIALISTS

Patient Signature Date

Patient Name Printed Patient Date of Birth

Insulin Pump Users

Name **Date**

Type of Pump_____

Is it still under warranty?_____

Pump Settings:

Insulin sensitivity ratio:

Carb ratio:

Correction formula:

Basal rates
1. MN _____
2. _____
3. _____
4. _____
5. _____

Typical bolus for

Breakfast _____ - _____ units

Lunch _____ - _____ units

Dinner _____ - _____ units

Snack _____ - _____ units
Bedtime _____ - _____ units

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Records Release Form

Patient Name _____ DOB _____

I hereby authorize the release of records **to** _____

from _____.

Please include the most current diagnosis, notes, labs, scans, radiology reports, consultation letters, etc.

Or specified records of: _____.

Signature _____ Date _____

PLEASE FAX TO 855-364-4963