North Georgia Diabetes & Endocrinology

Geetha R. Soodini, M.D.

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Patient Information Form

Last Name:______________________ First Name____________________ Middle______________

Date of Birth:___/___/_____SSN: ____/____/_____ Gender: Male/Female Marital Status: Single Married
MM DD YYYY Widowed Divorced

Home Phone:(____) _____-______Work Phone:(____)____-_____Cell Phone:(____)____-_____

E-mail Address:____

Home Address: ______________________________City: ___________State: ___Zip Code:_______

Emergency Contact Name:_________________________________ Relationship:_______________

Home Address:_______________________________ Zip Code: _______City: _________State:___

Home Phone:(____) _____-______ Work Phone:(____)____-_____Cell Phone:(____)____-____

Pharmacy Name:___________________ Location:__________ Phone Number:(____)____-_____

Primary Care Physician:____________________ Phone Number:(____)_____-_______

Referring Physician:________________________ Phone Number:(____)_____-_______

Employer Name:_______________________________ Employment Status: ___________________

Address: ______________________________ City: _______________State: ___ Zip Code:_______

Insurance Information:

Primary Insurance

Policy Holder:_____________________ Relationship:_____________ D.O.B. ____/____/_______

SSN: ______-_____-_______

I.D./Policy Number:_________________________ Group Number:__________________________

Secondary Insurance

Policy Holder:____________________ Relationship:_______________ D.O.B:____/____/______

SSN: _____-_____-_______

I.D/Policy Number:__________________________ Group Number:_________________________

Patient Name: ________________________________

Geetha R. Soodini, M.D.

Medical Consent Authorization: The undersigned hereby authorizes North Georgia Diabetes & Endocrinology and all employees/agents thereof to administer such treatment and/or perform such procedures as the physician. This consent is only for services rendered via NGDE authorize the assigned physician to administer such treatment as is necessary and to provide such consultations as may be necessary.

Release of Information: I authorize NGDE to disclose all or part of my medical records to any insurance carrier or person employed by such carrier of the purpose of collecting insurance benefits so long as I am listed on this account as having coverage with such carrier. This authorization includes release of information to employees for group insurance coverage, workers compensation carriers, and welfare agencies, if applicable to my claim for treatment. I hereby indemnify and release NGDE from any and all responsibility relative to such information.

Assignment of Benefits: I assign direct payment to NGDE of all medical benefits applicable to my treatment and diagnostic procedures at NGDE and grant NGDE Power of Attorney in the collection of benefits. This assignment is applicable to all future charges and fees from and including this day forward unless otherwise revoked in writing by me. I understand that I am totally responsible for payment of all fees for services rendered irrespective of insurance coverage or other responsible parties.

Surety Agreement: In accordance with above terms, and in consideration of the facility agreement to render information and furnish supplies, the undersigned patient and/or undersigned surety do hereby agree upon demand to pay NGDE and this facility, its agents or assigns whatever sums of money that shall become due on the amount of the patient and that such liability be joined.

Patient's Certification Authorization: I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or representatives, any information needed for this or a related Medicare claims. I authorize and direct that payment of benefits be made on behalf of NGDE.

______________________________________ ________________ ______________________

Undersigned (Signature of Patient or Gaurdian) Date Relationship to patient

___________________________ _______________

Signature of Witness Date

Acknowledgement of Patient Payment Responsibilities

Verification and Payment Amount

As a courtesy, we verify your insurance benefits prior to your appointment. We encourage you to contact your insurance company directly for verification.

Cancellations

Our office has a 24-hour voicemail. If you need to cancel, please call our office and leave a message indicating your name, appointment time, and reason for cancellation. **<u>If you do not call to cancel there will be a $25 fee for "No Show" appointment added to your account.</u>**

Signature____ Date______________________________________

North Georgia Diabetes & Endocrinology

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Cumming, GA. 30041

ENDOCRINOLOGY PATIENT INTAKE FORM

Please complete the following questions so y0ur doctor will have a record of your past and present medical history.

Patient Name:_________________________Date of Birth__________________Today's Date_________________

Reason for Current Visit:____

Referring Physician:_____________________________Phone:___________________Fax:___________________

PAST MEDICAL HSITORY: **Please circle all that apply**

Depression	Blood Transfusion	Rheumatoid arthritis
Diabetes Type I	CHF	Seasonal Allergies
Diabetes Type II	COPD	Seizure Disorder
Hyperlipidemia (High Cholesterol)	Coronary Artery Disease	Stroke
Hypertension (High Blood Pressure)	Crohn's Disease	TIA
Hyperthyroidism	Cushing's Disease	Vascular Heart Disease
Hypercalcemia	GERD	Cancer – Breast
Osteoarthritis	HIV	Cancer – cervical
Pituitary tumors	Kidney Stone	Cancer – Colon
Thyroid Disorder	Cirrhosis	Cancer-Prostate
Acromegaly	Hepatitis A	Other_____________
Anemia	Hepatitis B	__________________
Anxiety	Hepatitis C	__________________
Asthma	Osteopenia	__________________
Autoimmune Disorder	Osteoporoisis	________________

ENDOCRINOLOGY PATIENT INTAKE FORM

PAST SURGICAL HISTORY: Please circle all that apply and date of surgery

Bypass Surgery ___________________________	Anesthesia Problems	YES	NO
Pacemaker/Defibrillator____________________	Surgical Complications	YES	NO
Stent/Angioplasty_________________________	Post Op Delirium	YES	NO
Thyroidectomy___________________________	Other:___________________________________		

FAMILY HISTORY: Please circle all that apply

I am adopted	Yes				
Diabetes	Mother	Father	Both Parents	Brother	Sister
Thyroid Disease	Mother	Father	Both Parents	Brother	Sister
Thyroid Nodules	Mother	Father	Both Parents	Brother	Sister
Hyperthyroidism	Mother	Father	Both Parents	Brother	Sister
Hypothyroidism	Mother	Father	Both Parents	Brother	Sister
Alcoholism	Mother	Father	Both Parents	Brother	Sister
Anemia	Mother	Father	Both Parents	Brother	Sister
Arthritis	Mother	Father	Both Parents	Brother	Sister
Anxiety	Mother	Father	Both Parents	Brother	Sister
Asthma	Mother	Father	Both Parents	Brother	Sister
Blood Clots	Mother	Father	Both Parents	Brother	Sister
Depression	Mother	Father	Both Parents	Brother	Sister
Growth Develop/Disorder	Mother	Father	Both Parents	Brother	Sister
Headaches	Mother	Father	Both Parents	Brother	Sister
Heart disease	Mother	Father	Both Parents	Brother	Sister
Hypertension	Mother	Father	Both Parents	Brother	Sister
High Cholesterol	Mother	Father	Both Parents	Brother	Sister
Osteoporosis	Mother	Father	Both Parents	Brother	Sister
Seizures	Mother	Father	Both Parents	Brother	Sister
Cancer:__________	Mother	Father	Both Parents	Brother	Sister

ENDOCRINOLOGY PATIENT INTAKE FORM

Glucose Monitored: YES NO If yes, last reading;______________________________

Dietary Changes: Low Fat Low Salt Counting Carbs Weight Reduction Diet Other:_____________

Do you exercise regularly? YES NO How many times per week?_______

Types of exercise:_________________________ _________________________ ________________________________

SOCIAL HISTORY: please circle all that apply:

Single Married Widowed Divorced Separated

Occupation:____________________________________ Education:____

RISK FACTORS:

Do you use tobacco? YES QUIT:________________(year) NEVER

If currently smoking cigarettes, how many packs per day? ____________

If currently smoking cigars, How many per week? ____________________

Do you drink alcohol? YES NO How many drinks per day?___________

Do you drink Caffeine? YES NO How many caffeinated beverages per day?______________

MEDICATIONS: List all medications you are currently taking:

MEDICATION	DOSE	HOW OFTEN
___________________________	___________________	_________________________
___________________________	___________________	_________________________
___________________________	___________________	_________________________
___________________________	___________________	_________________________
___________________________	___________________	_________________________
___________________________	___________________	_________________________
___________________________	___________________	_________________________
___________________________	___________________	_________________________
___________________________	___________________	_________________________

ALLERGIES: List medication allergies and reactions (Hives, Swelling. ETC)

Review of Systems

General

Weight loss O Yes O No

Weight gain O Yes O No

Fatigue O Yes O No

Eye

Loss of vision O Yes O No

Double vision O Yes O No

Bulging eyes O Yes O No

Dry eyes O Yes O No

ENT

Persistent hoarseness O Yes O No

Sinus Congestion O Yes O No

Cardiac

Chest pain or pressure O Yes O No

Palpitations O Yes O No

Leg swelling O Yes O No

Lungs

Shortness of breath O Yes O No

Cough O Yes O No

Wheezing O Yes O No

Dermatology

Excessive dry skin O Yes O No

Excessive hair growth O Yes O No

Acne	O Yes	O No
Vitilig	O Yes	O No
Skin ulcer	O Yes	O No

Neurologic

Tremor	O Yes	O No
Frequent headache	O Yes	O No
Tingling	O Yes	O No
Numbness	O Yes	O No
Burning pain in feet	O Yes	O No
Seizures	O Yes	O No

Psychiatric

Depression	O Yes	O No
Sleep disturbances	O Yes	O No
Eating disorder	O Yes	O No
Anxiety	O Yes	O No

Endocrinology

Excessive thirst	O Yes	O No
Sensitive to cold temperature	O Yes	O No
Sensitive to hot temperature	O Yes	O No
Urination at night	O Yes	O No
Breast growth (men)	O Yes	O No
Breast discharge	O Yes	O No

Gastrointestinal

Constipation	O Yes	O No

Diarrhea O Yes O No

Vomiting O Yes O No

Nausea O Yes O No

Heartburn O Yes O No

Abdominal pain O Yes O No

Urinary

Difficulty urinating O Yes O No

Nocturia O Yes O No

Poor libido O Yes O No

Gynecological

Number of pregnancies O 0 O 1 O 2 O 3 O 4 O 5 O 6 O 7 O 8

Number of miscarriages O 0 O 1 O 2 O 3 O 4 O 5 O 6 O 7 O 8

Number of live births O 0 O 1 O 2 O 3 O 4 O 5 O 6 O 7 O 8

How many greater than 9lbs? O 0 O 1 O 2 O 3 O 4 O 5 O 6 O 7 O 8

Irregular Periods O Yes O No

Hot flashes O Yes O No

Musculoskeletal

Joint stiffness O Yes O No

Joint pain O Yes O No

Back pain O Yes O No

Muscle cramping O Yes O No

Fracture O Yes O No