PATIENT INFORMATION **L A** **Date:** ______________

Name: ____
Last Name First Name Middle Initial

Address: ____
Street City State Zip Code

Date of Birth: _____/______/_______ Home Phone Number: (_____)__________________
Month Day Year

Work Phone Number: (______)________________ Cell Phone Number: (______)__________________

Email Address: ____

SS#:_____-____-_______ Occupation:______________________ Employer: ______________________

Male ☐ Married ☐ Divorced ☐ Widowed ☐
Female ☐ Single ☐ Separated ☐

Primary Care Doctor:______________________ Phone: (______)___________ Fax: (______)____________

Address:____

SPOUSE OR CONTACT PERSON

Name: ______________________________________ RELATIONSHIP:________________
Last Name First Name Initial

Address: ____
Street City State Zip Code

Home Phone Number:(______)__________________ Work Phone Number:(______)__________________

SS#:_____-____-_______ Date of Birth: _____/______/_______ Occupation:____________________

Employer: ________________________

VOICE MESSAGE CONSENT

I authorize you to leave a message(s) for me at the following number(s):

____ Fax:______________________

CONSENT TO SHARE MEDICAL INFORMATION

I give my permission to release or exchange information regarding my medical condition and treatment between my endocrinologist, his staff, and family members/contact persons.

Yes ☐ No ☐

If yes, please provide the following:

Name:____, relationship: ________________________

Name:____, relationship: ________________________

By signing this form I understand all information shared is considered confidential. I authorize payment of medical benefits to undersigned Physician or supplier for these services and all future claims. I authorize the release of any medical information necessary to process this claim and all future claims

SIGNATURE:____ Date:____________________________

NAME: ______________________________________ A C O L

Please answer one set of questions once a year.

Date: ___________________

1. **Have you had a flu shot last season?** **YES** **NO**
2. **Have you had pneumonia shot in the last 5 years?** **YES** **NO**
   If yes, when and where did you last have your injection? ______________________________
   ____
   ____
3. **Have you ever had a DXA Bone Density scan?** **YES** **NO**
   If yes, where and when did you have your last scan? _________________________________
   ____
   ____
4. **Do you use tobacco?** **YES** **NO**
5. **Do you drink alcohol?** **YES** **NO**
6. **Do you use illicit drugs?** **YES** **NO**

Date: ___________________

1. **Have you had a flu shot last season?** **YES** **NO**
2. **Have you had pneumonia shot in the last 5 years?** **YES** **NO**
   If yes, when and where did you last have your injection? ______________________________
   ____
   ____
3. **Have you ever had a DXA Bone Density scan?** **YES** **NO**
   If yes, where and when did you have your last scan? _________________________________
   ____
   ____
4. **Do you use tobacco?** **YES** **NO**
5. **Do you drink alcohol?** **YES** **NO**
6. **Do you use illicit drugs?** **YES** **NO**

Date: ___________________

1. **Have you had a flu shot last season?** **YES** **NO**
2. **Have you had pneumonia shot in the last 5 years?** **YES** **NO**
   If yes, when and where did you last have your injection? ______________________________
   ____
   ____
3. **Have you ever had a DXA Bone Density scan?** **YES** **NO**
   If yes, where and when did you have your last scan? _________________________________
   ____
   ____
4. **Do you use tobacco?** **YES** **NO**
5. **Do you drink alcohol?** **YES** **NO**
6. **Do you use illicit drugs?** **YES** **NO**