PATIENT INFORMATION **L T** **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: _____ L T

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**

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6. **Do you use illicit drugs?** **YES** **NO**