Denver Endocrinology
Health Intake Form

Date: _____

Patient First Name: _____ MI_____ Last Name: _____

Mailing Address: _____ Apt/Unit #:_____

City: _____ State: _____ Zip: _____

Primary phone □cell □home: _____ Secondary phone □cell □ home: _____

SSN: _____ Date of Birth: _____ Marital Status: ☐M ☐S ☐D ☐W

Sex: ☐Female ☐Male Employer's Name: _____ Work Phone: _____

Patients Email Address:_____Web enable: Y☐or ☐N
(For our patient satisfaction surveys/patient web portal)

Race: _____(optional) Ethnicity: _____(optional) Language: _____

Emergency Contact Name: _____ Phone Number:_____ Relation:_____

HOW DID YOU LEARN ABOUT US?

□ Physician's Name _____	□ Bing	□Twitter	□ Yelp.com
□ Family/Friends	□ Yahoo	□ Facebook	□ Vitals.com
□ Google	□ Insurance	□ www.denverendo.com	□ Healthgrades.com
□ Zoc Doc	□ Other _____		

Health Insurance Information (ALL FIELDS ARE REQUIRED)

Primary Insurance Name: _____ Customer Service Phone#. _____

Policy Holder Name: _____ **SSN**: _____ **Date Of Birth**: _____

Phone #: _____ Policy Holder Employer: _____

ID Number: _____ Group/Policy #: _____

Secondary Insurance Name: _____ Customer Service Phone#. _____

Policy Holder Name: _____ SSN: _____ Date Of Birth: _____

Phone #: _____ Policy Holder Employer: _____

ID Number: _____ Group/Policy #: _____

- We bill your insurance company as a courtesy to you. It is your responsibility to know your benefits, and you are ultimately responsible for payment if a service is not covered. Please be prepared to make a payment or co-payment at the time of service. Thank you

To better serve you please provide us with the following information:

Referring Physician Information:

First Name: _____ Last Name: _____

Phone Number: _____

Primary Care Physician Information:

First Name: _____ Last Name: _____

Phone Number: _____

Primary Pharmacy Information

Name: _____ Phone: _____

Address:_____

Denver Endocrinology

Co-pay and referral policy

We require all co-pays be paid at the time of service. If we participate with your insurance plan we will bill your insurance as a courtesy to you.

Your insurance may require that you receive a referral from your primary care provider. If this is the case please make sure that your doctor sends that over to our office so that your visit will be paid for. If we do not receive this information, we will bill the visit directly to you.

If you are an uninsured patient, we offer a 35% discount if you pay at the time of service. If you are unable to pay you will need to contact our billing office to set up a payment plan.

I understand this policy and accept the terms.

_____ _____

Patient signature Date

Denver Endocrinology

NO SHOW POLICY

Our goal here at Denver Endocrinology is to provide quality service to our patients. Failure to keep scheduled appointments is costly to the practice, yourself and other patients. This notice is to inform you of our policy concerning "No Shows".

Patients who are not able to keep their appointments are asked to cancel at least 24 hrs prior to their appointment. Providing this notice gives us the opportunity to work in the other patients who are on a waiting list and thus utilizing our physicians' time in a wise manner. If any patient cancels or does not show for his/her appointment more than 2 times, they will be considered dismissed from the practice.

I have read this policy and understand the details within it and accept the terms.

_____ _____

Patient Signature Date

How Can We Reach You?

HealthONE Clinic Services

PHONE MESSAGE CONSENT

Your provider will at times need to contact you. By filling out the information below we will be better able to serve you.

Name: _____

In an effort to protect your privacy, we will have developed a policy on leaving medical care messages:

- We will ***NOT*** leave messages with anyone except the patient or legal guardian.
- We will ***NOT*** leave any confidential information on an answering machine.
- We will ***NOT*** leave any message on a voice mail.

UNLESS

WE HAVE YOUR WRITTEN PERMISSION TO DO SO.

Please read below and consider carefully whom you authorize to have access to protected information regarding your care.

I, _____ give HealthONE my permission to speak with and/or leave messages regarding my medical care and/or billing with the following. I fully understand that this consent will remain valid until revoked in writing.

My **Home** answering machine: # _____ Initials: _____
My **Cell** voice mail: # _____ Initials: _____
My **Office/Work** voice mail: # _____ Initials: _____

Other Contacts:

Contact Name: _____ Relationship: _____

Phone #: _____ Initials: _____

Contact Name: _____ Relationship: _____

Phone #: _____ Initials: _____

Contact Name: _____ Relationship: _____

Phone #: _____ Initials: _____

Signature: _____ Date: _____

Name: _____ DOB: _____ Date:_____

MEDICAL HISTORY Please complete to the best of your ability.

Do you or have you ever had any of the following problems?

	Yes	No	Don't Know
Diabetes	☐	☐	☐

If yes, any complications (eye, kidney, nerve or foot problems)? _____
If yes, date of last eye appointment? _____
If yes, date of last HgA1C _____

Heart disease	☐	☐	☐
High blood pressure	☐	☐	☐
High cholesterol	☐	☐	☐
Thyroid disease	☐	☐	☐

If yes, what type? _____
(Low or high thyroid levels, goiter, thyroid nodule, or thyroid cancer)

	Yes	No	Don't Know
Pituitary problem	☐	☐	☐
Adrenal problem	☐	☐	☐
Osteoporosis	☐	☐	☐
Kidney stones	☐	☐	☐
Menstrual problems	☐	☐	☐

If so, what type? _____

Other medical problems (please list)

_____ _____ _____
_____ _____ _____

Current medications and dosages (please list)

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

Allergies and reactions

_____ _____ _____
_____ _____ _____

In the **past 6 months** have you experienced any of the following symptoms?

	Yes	No		Yes	No
Weight loss	☐	☐	Rash	☐	☐
Weight gain	☐	☐	Easy bruising	☐	☐
Fatigue	☐	☐	Acne	☐	☐
Fevers or Chills	☐	☐	Night sweats or Flushing	☐	☐
Headaches	☐	☐	Irregular menstrual periods	☐	☐
Blurred or double vision	☐	☐	Breast tenderness	☐	☐
Difficulty swallowing	☐	☐	Milk discharge from breasts	☐	☐
Hoarseness	☐	☐	Excessive hair growth	☐	☐
Palpitations (heart racing)	☐	☐	Hair loss	☐	☐
Chest pain	☐	☐	Dizziness	☐	☐
Shortness of breath or cough	☐	☐	Muscle weakness	☐	☐
Nausea/vomiting	☐	☐	Muscle pain	☐	☐
Constipation	☐	☐	Tremor	☐	☐
Diarrhea	☐	☐	Sexual dysfunction	☐	☐
Excessive thirst	☐	☐	(loss of interest or erections)		
Difficulty with urination	☐	☐	Numbness/tingling	☐	☐
			Depression/Anxiety	☐	☐
			Sleep disorder	☐	☐

SOCIAL HISTORY

Do you smoke cigarettes? _____ Packs per day? _____

Number of alcoholic drinks per week _____

Do you have a regular exercise routine? _____ If so, describe _____

If employed, what type of work do you do? _____ Any toxic exposures? _____

Marital status: _____

FAMILY HISTORY

Does anyone related to you by blood have the following conditions? (Circle)

- ☐ Diabetes
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Heart disease (age<45 for males and <55 for females)
- ☐ Thyroid cancer
- ☐ Low thyroid levels
- ☐ High thyroid levels
- ☐ Adrenal gland problem
- ☐ Calcium problem
- ☐ Pituitary problem
- ☐ Kidney stones
- ☐ Osteoporosis

Filled out by _____ Date _____

Patient Information:

Patient Legal Name _____Birthdate_____SS#_____

Address/City/State/Zip _____

Telephone number: _____Unit Number: _____

To / From

Denver Endocrinology
1601 E 19th Ave Suite 4350
Denver, CO 80218
Phone # 303-228-1240
Fax # 303-228-1250

To / From

_____
Name / Title / Organization
_____
Address/City/State/Zip
Telephone# _____Fax# _____

Purpose:

☐ Continuation of Care ☐ Insurance or Worker's Comp ☐ Legal ☐ Personal Use
☐ Other _____ For treatment date(s): _____

Access Requested:

☐ copies of the record
☐ Inspection of the record

Pertinent Info:

☐ D/C Summary 9 H&P
☐ Consult/Operative Report
☐ Lab/Radiology
☐ Emergency Room Record

Selected Portions:

☐ Outpatient Visit ☐ Behavioral Health Record
☐ Special Studies ☐ Entire Medical Record
☐ Physician Orders ☐ Billing Record
☐ Medication Record ☐ Other _____

Patient Authorization:

ACKNOWLEDGEMENT: *I request and authorize the above-named health care provider to release the information specified above to the organization or individual named on this request. I understand that the information to be released may include information regarding the following condition(s): Sickle Cell Anemia; Genetic testing; Human Immunodeficiency Virus (HIV); Drug Abuse, Alcoholism, Alcohol Abuse, if any; Acquired Immune Deficiency Syndrome (AIDS); or Psychological or psychiatric conditions, if any*

I understand that:

1. My signature on this form is strictly voluntary.
2. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy of Practices.
3. If the requester or receiver is not a health plan or health care provider, the released information may be disclosed by the recipient and may no longer be protected by federal privacy regulations.
4. Fees/charges will comply with all laws and regulations applicable to release of information.

Fees:

Note: HealthONE may charge a fee for copies of the medical records in accordance to Colorado State Law.

Phys Concurrence: If Applicable:

PHYSICIAN CONCURRENCE FOR PATIENT ACCESS:
_____has my permission to ***(inspect) (receive copies of)*** the requested medical records. I have reviewed the medical record(s) and have determined they ***(do) (do not)*** contain information relative to psychological or psychiatric problems, which, if revealed to the patient, would be reasonably likely to endanger the life or physical safety of the patient or another person. (If the patient has requested psychotherapy notes, such disclosure ***(would) (would not)*** have significant negative psychological impact upon the patient.)

Attending physician or designee: _____ Date: _____

Delivery Instructions:

☐ Call requestor for pick-up when records are ready.
☐ Mail records directly to person or organization specified.

☐ I authorize _____to pick up my Protected Health Information (PHI).
(Print Name)
_____
Relationship

Confirmation of PICK-UP
_____
Signature
_____
Date

Signature:

My signature is required to validate this Authorization. If I do not sign this form, my health care, the payment for my health care or my ability to enroll for benefits will not be affected.

_____
Date Patient or Authorized Representative Relationship to Patient
A copy is provided after signature.

EXPIRATION: Without my express revocation, this consent will automatically expire upon satisfaction of the need for disclosure, but in any event will expire 180 days from the date hereof, unless otherwise specified as follows: _____

OTHER CONDITIONS: A copy or facsimile of this Authorization with my signature may be used with the same effectiveness as an original.

Authorization for Use and Disclosure of Protected Health Information (PHI)

HealthONE USE ONLY
Verification:
Date Authorization Received: _____ By:_____
Date Request Completed: _____ By: _____
Identification/Driver's License # Verified: _____
☐ Power of Attorney ☐ Other _____