NORTH TEXAS
ENDOCRINE CENTER

Patient Registration Form

Date: ____________________

Last Name: ________________________________ **First**: ___________________________ **Middle**: ___________________

____
Street Address City State Zip

Home Phone: ________________________ Work Phone: _____________________ Mobile Phone: _____________________

Date of Birth: ____________________________ Social Security: ______________________________ Sex: Male Female

Martial Status: Single Married Widowed Divorced Email: ____

Occupation: ____ Employer: ____

Referring Physician: ____ Phone: __________________________________

Primary Care Physician: ____ Phone: __________________________________

Pharmacy Name: ____ Phone: __________________________________

Emergency Contact: ____________________________ Relationship: __________________ Phone: _______________________

Please list known allergies to medications here: ____

Primary Insurance Information:

Insurance Company Name: ____

Insurance Company Address: ____

Insurance Company Phone: _____________________________ Employer (if group coverage): __________________________

Policy ID: ____________________________________ Group Name and/or #: ____

Subscriber Name: __________________________ Date of Birth: _________________ Social Security: _____________________

Secondary Insurance Information: ____N/A

Insurance Company Name: ____

Insurance Company Address: ____

Insurance Company Phone: _____________________________ Employer (if group coverage): __________________________

Policy ID: ____________________________________ Group Name and/or #: ____

Subscriber Name: __________________________ Date of Birth: _________________ Social Security: _____________________

Patient / Guardian Signature: ____

North Texas Endocrine Center
9301 North Central Expressway, Tower II, Suite 570
Dallas, TX 75231
Phone 214-369-5992   Fax 214-369-2414

Welcome to North Texas Endocrine Center

Please find enclosed information regarding our office policies and procedures. This includes information about your responsibilities as a patient as well as your privacy rights. If you have any questions regarding any of this information, please do not hesitate to ask.

Also enclosed, you will find a general medical history, review of systems form, and a medication list. Please complete this information to the best of your ability and bring it with you to your appointment. Please contact your referring physician and ask that they forward any additional medical information such as clinic notes, laboratory reports, ultrasound reports, and any other information pertaining to your condition. This information can be mailed to us at the address above and faxed to us at 214-369-2414. Not having this information for your appointment may result in your appointment being rescheduled.

If you are being seen for diabetes: please bring your recent blood glucose readings and your blood glucose monitor with you to your appointment.

If you are unable to keep your scheduled appointment, please contact our office at 214-369-5992 within 48 hours to cancel or reschedule your appointment. We look forward to stabling a relationship with you and providing quality healthcare for your endocrine problems.

Sincerely,

North Texas Endocrine Center

North Texas Endocrine Center

Medical History

Patient Name:________________________________ Date of Birth:_______________

FAMILY MEDICAL HISTORY

Anyone in your immediate family has ever had any of the following, please mark correct box.

	Mother	Father	Grand Parent	Brother Sister
Heart Attack				
Cancer				
Hypertension				
Stroke				
Diabetes				
Thyroid Disease				
Osteoporosis				
Elevated Cholesterol				
Kidney Stones				

	Yes	No
Are you married?		
Do you have children?		

	Yes	No
Is your mother still alive?		

If not, her age at death?__________________________

Cause of death?________________________________

Is your father still alive?

If not, his age at death?__________________________

Cause of death:________________________________

PERSONAL MEDICAL HISTORY

	Yes	No
Have you ever had any chronic or serious illnesses?		

If yes, please explain:__________________________

____

____

____

____

____

SMOKING HISTORY

	Yes	No
1. Have you ever smoked?		
2. Do you presently smoke?		
3. Have you ever tried to quit?		

EXERCISE HISTORY

	Yes	No
1. Do you exercise at all?		

2. How often?________________________________

3. What type of exercise?________________________

NUTRITION HISTORY

	Yes	No
1.Have your cholesterol or trygleride levels ever been elevated?		

2. What were your last known levels?_______________

3. Are you on a special diet?

4. Have you gained weight in the past year?

5. If yes, how much?___________________________

6. Have you gained weight in the past? 5 years?

7. If yes, how much?____________________________

8. Have you ever tried to lose weight?

9. Weight at age 21?____________________________

10. What is your approximate intake of:

***Bottles of beer?___________________________

***Glasses of wine?___________________________

***Ounces of Liquor?__________________________

MEDICATIONS

	Yes	No
1. Do you take any medication?		

If yes, please list on medication page.

2. Are you allergic to any medication?

If yes, please list on medication page.

Have you had any operations?

If yes, list operation and approx age____

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____

____

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PATIENT MEDICATION LIST

Patient Name:________________________________ Date:_______________________

Please list known allergies to medications here:____________________________________

What prescriptions are you currently taking?

MEDICATION NAME	DOSAGE/STRENGTH	HOW OFTEN TAKEN?

What OTC (over the counter) medications are you currently taking?

MEDICATION NAME	DOSAGE/STRENGTH	HOW OFTEN TAKEN?

NORTH TEXAS
ENDOCRINE CENTER

AUTHORIZATION FOR RELEASE /REQUEST OF MEDICAL RECORDS

PATIENT NAME:______________________________ DATE OF BIRTH:__________________

ADDRESS:____

HOME PHONE:______________________________ MOBILE:______________________

_______PLEASE RELEASE MY MEDICAL RECORDS TO:

NORTH TEXAS ENDOCRINE CENTER

9301 N. CENTRAL EXPRESSWAY

TOWER II, SUITE 570

PHONE: 214-369-5992

FAX: 214-369-2414

_______ PLEASE RELEASE MY MEDICAL RECORDS FROM NORTH TEXAS ENDOCRINE CENTER TO:

PHYSICIAN/FACILITY NAME____

ADDRESS:____

PHONE:__________________________ FAX:____________________________________

THIS AUTHORIZATION APPLIES TO THE FOLLOWING INFORMATION:

______ALL RECORDS ______LABORATORY REPORTS ___________ RADIOLOGY

REPORTS______________OTHER:____

PATTIENT/GUARDIAN SIGNATURE______________________________ DATE______________