ENDOCRINE & DIABETES CLINIC

Welcome to Endocrine & Diabetes Clinic!

It is our mission to serve as your leader and premier provider of endocrine and diabetes related medical services by continually learning, growing, and partnering with you, our patients, as well as our employees and other healthcare providers. As we strive to achieve excellence on a daily basis, it is our commitment to provide you with the highest level of quality and personal and compassionate care.

Enclosed you will find detailed documents and forms which outline our policies as well as other information important for your visit. If you have questions, please contact us prior to your appointment. Please take a few moments to complete these forms and bring them to your first visit.

Our practice follows certain guidelines and recommendations with which we ask to you become familiar.

- Please arrive 15 minutes prior to your scheduled appointment time in order to complete and/or review required paperwork. You may be asked to reschedule your appointment if your arrive more than 15 minutes later than your scheduled appointment time.
- Please bring all of your insurance cards, prescription cards, and photo ID with you to each scheduled appointment and notify us if your insurance should change.
- We will collect your co-payment, deductible, and/or past due balances prior to your visit with the provider. We accept cash, check, or credit card. Failure to make appropriate payments may result in having to reschedule your appointment.
- We will file all claims with your insurance carrier as appropriate and work with both you and your carrier to process these as quickly and accurately as possible. Patients are responsible to verify that their insurance is in-network with our providers and that any necessary prior authorization has been obtained from their insurance carrier. Patients may be responsible for payment of services not covered or paid by their insurance.
- Regular office hours are Monday through Thursday 8:00 am to 4:30 pm and Friday 8:00 am to 3:30 pm. Please request prescription refills during your office visit or call your pharmacy directly to request a refill. Routine medication refills are processed during office hours and are not processed at night or on weekends. When calling the clinic about a prescription or refill, please provide your pharmacy's name and phone number.
- Calls for the nurse or physician are returned as soon as possible, giving priority to emergencies and scheduled patients in the office. At the time of your call, please give us the best phone number and available times for returning your call.
- Please allow us up to two weeks to contact you regarding lab/test results or as otherwise communicated by the provider or nurse

We appreciate your consideration and patience in assisting us to better serve you.

ENDOCRINE & DIABETES CLINIC, PLLC.
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION MAY BE USED AND DISCLOSED AND HOW TO OBTAIN THIS INFORMATION. PLEASE REVIEW CAREFULLY. YOU HAVE THE RIGHT TO OBTAIN A COPY OF THIS NOTICE UPON REQUEST.

Patient Health Information

Under federal law, your patient health information (PHI) is protected and confidential. Patient health information includes information about your symptoms, test results, diagnosis, treatment, and related medical information. Your health information also includes payment, billing, and insurance information.

How We Use Your Patient Health Information

We are permitted to use and disclose patient health information for treatment, payment, and healthcare operations.

Examples of Treatment, Payment, and Health Care Operations

Treatment: We will use and disclose your health information to provide medical treatment or services. For example, nurses, physicians, and other members of your treatment team will record information in your record and use it to determine the most appropriate course of care. We may also disclose the information to other healthcare providers who are participating in your treatment, to pharmacists who are filling your prescriptions, and to family members who are helping with your care.
Payment: We will use and disclose your health information for payment purposes. For example, we may need to obtain authorization from your insurance company before providing certain types of treatment. We will submit bills and maintain records of payment from your health plan.
Healthcare Operations: We will use and disclose your health information to conduct our standard internal operations, including proper administration of records, evaluation of the quality treatment, and to assess the care and outcome of your case and others similar to it.

Special Uses

We may use your information to contact you with appointment reminders. We may also contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Other Uses and Disclosures

We may use and disclose identifiable health information about you for other reasons, even without your consent. Subject to certain requirements, we are permitted to give out health information about you for the following purposes.
Required by Law: We are required by law to report gunshot wounds, suspected abuse or neglect, or similar injuries and events.
Public Health Activities: As required by law, we may disclose vital statistics, diseases, information related to recalls of dangerous products, and similar information to public health authorities.
Health Oversight: We may be required to disclose information to assist in investigations and audits, eligibility for government programs, and similar activities.
Judicial and Administrative Proceedings: We may disclose information in response to an appropriate subpoena or court order.
Law Enforcement Purposes: Subject to certain restrictions, we may disclose information required by law enforcement officials.
Deaths: We may report information regarding deaths to coroners, medical examiners, funeral directors, and organ donation agencies.
Serious Threat to Health or Safety: We may use and disclose information when necessary to prevent serious threat to the health and safety of your, another person, or the public.
Military and Special Government Functions: If you are a member of the armed forces, we may release information as required by military command authorities. We may also disclose information to correctional institutions or for national security purposes.
Research: We may use or disclose information for approved medical research.
Workers Compensation: We may release information about you for workers compensation or similar programs providing benefits for work-related injuries or illnesses.

Uses and Disclosures that Require Patient Authorization

In other situations, we will require your written authorization before using or disclosing your identifiable health information, which may include the following: disclosures to life insurance companies; non court ordered subpoenas; disclosures for non-authorized research purposes; disclosures to employers; copies of medical records to patient or other patient representative; marketing; disclosing any psychotherapy notes; or disclosing information in exchange for remuneration. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures. Revocation requests must be made in writing and submitted to the clinic's Privacy Officer.

You have the following rights with regard to your health information. Please contact our office to obtain the appropriate form for exercising these rights.

Request Restrictions: You may request restrictions on certain uses and disclosures of your health information. We are not required to agree to all such restrictions, but if we do agree, we must abide by them. You have the right to opt out of fundraising communications. Additionally, you have the right to restrict disclosure of personal health information relatied to services for which you have paid out of pocket.

Confidential Communications: You may ask us to communicate confidentially by, for example, sending notices to a special address or not calling with appointment reminders.

Inspect and Obtain Copies: In most cases, you have the right to look or obtain a copy of your health information. There may be a charge for the copies:

Amend Information: If you believe that information in your record is incorrect or that important information is missing, you have the right to request that we correct the existing information or add the missing information. We are not required to agree to such amendment, but must let you know our reasons.

Accounting of Disclosures: You may request a list of instances where we have disclosed health information about you for reasons other than treatment, payment, or health care operations.

Notice of Breach: You have the right to be notified in the event there is a breach of your identifiable health information.

Our Legal Duty

We are required by law to protect and maintain the privacy of your health information, to provide this Notice about our legal duties and privacy practices regarding protected health information, to notify you following a breach of your protected health information (unless your information was encrypted or otherwise rendered unreadable or unusable) and to abide by the terms of the Notice currently in effect. Upon request, you may receive a copy of this notice.

Changes in Privacy Practices

We may change our policies at any time. Before we make a significant change in our policies, we will change our Notice and post the new Notice in the waiting area and each examination room. You may also request a copy of our Notice at any time. For more information about our privacy practices, contact our Privacy Officer.

Complaints

If you are concerned that we have violated your privacy rights, or if you disagree with a decision we have made about your records, please contact our Privacy Officer. You may also send a written complaint to the U.S. Department of Health and Human Services. The Privacy Officer will provide you with the appropriate address upon request. You will not be penalized in any way for filing a complaint.

Contact Person / Privacy Officer

If you have any questions, complaints, or requests, please contact:

Tracey Wren-Cox, Practice Director
290 S Walnut Bend
Cordova, TN 38018
(901) 266-1080

This Notice became effective June 18, 2007, and was revised on August 10, 2015

ENDOCRINE & DIABETES CLINIC

Date:

PATIENT DEMOGRAPHIC FORM

PATIENT INFORMATION

Last Name | **First Name** | **Middle Name** | **Preferred Name**

Date of Birth | **Social Security Number** | **Sex**

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Life Partner ☐ Separated ☐ Widowed **Primary Language**

Race (Optional) ☐ Caucasian ☐ Black / African American ☐ Asian ☐ Native American / Alaskan Native

Ethnicity (Optional) ☐ Non Hispanic / Latino ☐ Hispanic / Latino ☐ Other: _____

Street Address | **City** | **State** | **Zip Code**

Home Phone | **Work Phone** | **Cell Phone**

Email Address (for patient portal access) **Is it okay to leave a message at:**
Home Y / N Cell Y / N Work Y / N

Employer | **Occupation** | **Preferred Method of Communication:**
Home / Cell / Email / Text / US Mail

PHYSICIAN REFERRAL / PHARMACY INFORMATION

Primary Care Physician | **Referring Physician**

Preferred Pharmacy / Location | **Pharmacy Phone Number**

INSURANCE INFORMATION

Primary Insurance | **Policy Number / Member ID** | **Group Number**

Name of Insured | **Relationship to Patient**

Secondary Insurance | **Policy Number / Member ID** | **Group Number**

Name of Insured | **Relationship to Patient**

Tertiary Insurance | **Policy Number / Member ID** | **Group Number**

Name of Insured | **Relationship to Patient**

EMERGENCY CONTACT(S)

Name | **Relationship** | **Phone Number** ☐ May discuss health information ☐ Leave message with call back # only

Name | **Relationship** | **Phone Number** ☐ May discuss health information ☐ Leave message with call back # only

Name | **Relationship** | **Phone Number** ☐ May discuss health information ☐ Leave message with call back # only

ENDOCRINE & DIABETES CLINIC, PLLC (EDC) - FINANCIAL & ADMINISTRATIVE POLICIES

RECEIPT OF NOTICE OF PRIVACY PRACTICES

- I acknowledge that I have received or reviewed a copy of EDC's Notice of Privacy Practices as required by HIPAA. This notice describes how EDC may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information.

Initial _____

PARTICIPATION IN TENNCARE, MEDICAID, AND HEALTHCARE EXCHANGE PLANS

- EDC does currently participate in BlueCare but DOES NOT participate in any other TennCare or Medicaid plans. EDC DOES NOT participate in the BlueCross BlueShield Network E or Advantage HMO plans. If EDC is not contracted with your plan, please contact your insurance plan to determine an appropriate in-network provider for your medical services.

DISCLOSURE OF TENNCARE/ MEDICAID COVERAGE

- By initialing you are certifying <u>one</u> of the following: ☐ NO, I do NOT have active or pending TennCare or Medicaid coverage
  ☐ YES, I DO have active or pending TennCare or Medicaid coverage

Initial _____

APPOINTMENT CANCELLATION POLICY

- EDC requires a 24 hour cancellation notice for any scheduled medical appointment or surgery/procedure.
- No shows and cancellations without a 24-hour notice may receive a $35.00 charge for missed office visits.
- This charge will be the patient's responsibility and will not be billed to or reimbursed by your insurance.
- If a patient repeatedly misses or cancels appointments, the patient may be dismissed from the practice.

Initial _____

PATIENT PAYMENT POLICY AND COVERED SERVICES

- It is the policy of EDC to collect all patients balances, co-pays, deductibles, and/or co-insurance due from patients at the time of service.
- Our office may contact your insurance carrier to verify your insurance coverage and benefits. Our staff will make their best effort to determine or estimate your financial responsibility according to the contractual agreement between EDC and your insurance company for these services.
- If your insurance claim is denied due to incorrect personal information or incorrect insurance information that you have provided, you will be billed for any unpaid claims for your services, and payment in full will be due immediately.
- If your account or any account for which you are responsible is sent to a collection agency due to non-payment of any patient balance, you may be dismissed from EDC for any future care and services, which includes all providers at EDC. Additionally, you will be responsible to pay for the collection agency fees (up to 35% of unpaid balance) and any attorney fees associated with the collection of your account.
- Your health insurance plan may not provide coverage for all medical services, tests, and/or procedures that our providers may offer or recommend for your treatment. <u>It is your responsibility</u> to know and understand the services covered by your insurance, and if your insurance does not cover these services, you will be responsible for payment.
- If you do not have medical coverage and insurance through a carrier with which EDC participates, or if you are a new patient and cannot supply your valid insurance card, or if your coverage cannot be determined, you must pay in full at the time of service.
- Certain labs collected in this office may be sent to an outside lab for testing. As such, you may be billed by that reference lab for these.
- Please verify that any referral or prior authorization has been obtained prior to receiving additional medical services.

Initial _____

RETURNED CHECK CHARGE

- EDC will charge the patient account $25.00 for any returned checks to cover EDC's cost for any related bank charges.

Initial _____

CONSENT FOR RELEASE OF PROTECTED HEALTH INFORMATION

- By signing below, you authorize this office to release your protected health information (PHI), including account status, test results, scheduled appointments, and information regarding your treatment of the persons (in addition to the patient) you have listed below:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Any person who is not listed above will not be able to obtain your protected health information. It is not necessary to list other treating physicians, insurance carriers or other covered entities. This Authorization is valid and effective (Endocrine & Diabetes Clinic) for a 5 year period/duration from initial date of service.

Patient Signature: _____ Date: _____

PERSONAL INFORMATION VERIFICATION

- As it is our policy to verify your demographic and insurance information at every visit to help insure that claims are processed timely and accurately, please bring your insurance card with you to every visit.
- Additionally, a photo ID will be requested from all patients.

Initial _____

PERSONAL INFORMATION VERIFICATION

- There is a minimum fee of $20.00 for the release of medical records which is the responsibility of the patient to pay prior to receiving the records. For records that exceed twenty (20) pages, there may be an additional charge of $0.50 per page for all pages exceeding the first twenty (20) pages. A $20.00 fee will be charged to complete up two (2) forms for FMLA and standard disability. An additional fee of $25.00 will be charged for submitting subsequent forms.

Initial _____

Patient Signature _____ Patient Printed Name _____

Date _____ Patient Chart # _____ EDC Initials _____ eff: 7/1/15

SIGNATURE SECTION

To the best of my knowledge, the information on the registration form is complete and correct. I understand that it is my responsibility to inform my doctor and his staff if there is a change in health, insurance and/or contact information.

Patient Signature:_____ Date: _____

CONSENT TO TREATMENT

I voluntarily consent to medical care at **Consolidated Medical Practices of Memphis** for routine diagnostic examination and medical treatment including, but not limited to, routine laboratory work (such as blood, urine and other studies), taking of x-rays, heart tracing and administration of medications prescribed by the physician.

I further consent to the performance of those diagnostic procedures, examinations and rendering of medical treatment by the medical staff and their assistants, including nurse practitioners, physician's assistants, medical assistants or their designees as necessary in the medical staff's judgment. This consent is valid and remains in effect as long as I receive medical care at **Consolidated Medical Practices of Memphis**.

I promise as a patient of **Consolidated Medical Practices of Memphis** that I will follow all office policy that pertain to the patients of the office. I understand that if I am not compliant with following the physicians' plan of care, I can be terminated from the practice. By signing this I agree to follow the plan of care to the best of my ability.

Patient Signature:_____ Date: _____

PRIVACY STATEMENT

We consider any information that concerns your health, health care, or payment for that care to be confidential and protected information. This notice describes our privacy practices, specifically how we use and disclose your medical information and what rights you have with respect to this information. This information includes your name, address, and other identifying data, and information on your health or the health services that have been or may be furnished to you. We require all of our employees, staff, volunteers, and independent contractors to comply with these privacy practices. We are required by federal law to obtain an acknowledgment from you that you received this notice.

Patient Signature:_____ Date: _____

BENEFIT AUTHORIZATION

(a) I authorize **Consolidated Medical Practices of Memphis** to release medical information to third party insurance carriers for the purpose of filing insurance claims related to my medical care.
(b) I also request that payments of authorized benefits be made to me or on my behalf to **Consolidated Medical Practices of Memphis** for services rendered.
(c) I further authorize the release of medical information about treatment here to my doctor or anyone designated by me.
(d) I authorize the use of my signature on all insurance submissions.
(e) I understand I am responsible for payment of all medical expenses incurred due to services rendered at the time of service.
(f) I agree to provide complete and accurate information about all insurance policies that I participate in and advise the doctor and staff for any changes.

Patient Signature:_____ Date: _____

RELEASE OF INFORMATION DESIGNATION

I authorize physicians and staff of **Consolidated Medical Practices of Memphis** to speak with the following people regarding insurance and billing concerns.

Name:_____ Phone #:_____ Relationship:_____

I authorize physicians and staff of **Consolidated Medical Practices of Memphis** to speak with the following people regarding my health care, plan of treatment, medications, and lab/test results.

Name:_____ Phone #:_____ Relationship:_____

ACCOUNT COLLECTIONS AGREEMENT

In the event that your account is placed with a Collection Agency, a collection-fee of up to 33.3% may be added to your account and shall become a part of the Total Amount Due. In the event your account is placed with an Attorney, you will be responsible for the reasonable Attorney fees and court cost.

You agree, that in order for us to service your account or to collect any amounts you may owe we and our collection agencies may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We and our collection agencies may also contact you by sending text messages or emails, using any email address you provide to use. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

Patient Signature:_____ Date: _____

ENDOCRINE & DIABETES CLINIC

Clinical History Form

Medication

Please list all prescription and non-prescription medications, including nutritional supplements you currently take.

Medication	Dosage & Frequency	Medication	Dosage & Frequency

Allergies

List all prescription and non-prescription medications to which you have had a reaction and describe the reaction.

Drug	Reaction	Drug	Reaction

Review of Systems

General	Y	N	Neck	Y	N	Cardiovascular	Y	N	Genitourinary	Y	N
Weight Loss			Neck/ Throat Pain			Chest Pain			Urination at Night		
Weight Gain			Neck Swelling			Palpitations			Excess Urination		
Fever			Hoarseness			Ankle Swelling/Edema			Blood in Urine		
Night Sweats			Sore Throat			Dyspnea on Exertion			Decreased Libido		
Fatigue			Trouble Swallowing			Calf Pain on Walking			Erectile Problem		
Difficulty Sleeping			Other			Other			Incontinence		
Endocrine			**Respiratory**			**Musculoskeletal**			**Neurologic**		
Intolerance to Heat			Difficulty Breathing			Back Pain			Headache		
Intolerance to Cold			Cough			Knee Pain			Dizziness		
Excessive Thirst			Bloody Sputum			Other Joint Pain			Head Spinning		
Excess Body Hair			Snoring			Diffuse Joint Pain			Fainting		
Abnormal Bruising			**Gastrointestinal**			Muscle Aches			Limb Weakness		
Excessive Sweating			Changes in Appetite			**Skin**			Tingling		
Irregular Menses			Acid Reflux			Itching			Numbness		
Vision, Hearing			**Nausea**			Dry Skin			Tremors		
Lack of Smell			**Vomiting**			Rash			**Psych**		
Decreased Hearing			**Abdominal Pain**			Hair Loss			Anxiety		
Ringing in the Ears			Diarrhea			Brittle Flaking Nails			Depression		
Eyesight Problem			Constipation			Dry Brittle Hair			Mood Swings		
Double Vision			Blood in Stools			Other			Other		

ENDOCRINE & DIABETES CLINIC

Clinical History Form

Tobacco Use History

☐ I currently smoke cigarettes	I have a plan to quit. I agree	☐ Completely	☐ Somewhat	☐ Not Really ☐ Not at All
Number of Packs/Day:	Number of Years:	Comments:		
☐ I have quit smoking	Quit Date:	How many years did you smoke before quitting?		
How many packs/day did you use to smoke?		Comments:		
☐ I live with household members who smoke	I use other forms of tobacco:	☐ Pipe	☐ Cigar	☐ Snuff ☐ Chew
☐ I have never smoked	☐ I have smoked, but rarely	Please Explain:		

Drug and Alcohol Use History

Have you ever used recreational drugs or needles? ☐ Yes ☐ No	If yes, please list what type:		
Describe how long and method of use:			
Do you drink alcohol? ☐ Yes ☐ No	Drinks/Week:	Is alcohol use a concern for you or others? ☐ Yes ☐ No	

Socioeconomic History

Are you employed? ☐ Yes ☐ No	If yes, what is your occupation?			
Work Status: ☐ Full-Time	☐ Part-Time	☐ Homemaker	☐ Retired	☐ Unemployed ☐ Disabled ☐ Student
Education Completed: ☐ Grade School	☐ High School	☐ College	☐ Graduate School	
Number of Children:	Number of Household Members:			
Whom do you live with? ☐ Parents	☐ Spouse/SO	☐ Children	☐ Other Relatives	☐ Other Non-Relatives

ENDOCRINE & DIABETES CLINIC

Past Medical History

Endocrine	Y	Rheum / Renal	Y	Cardiovascular	Y	GI / Respiratory	Y
Diabetes Type 1		Rheumatoid Arthritis		Heart Attack		Reflux GERD	
Diabetes Type 2		Lupus		Angina (Chest Pain)		Celiac Disease	
High Cholesterol		Osteoarthritis		Heart Disease		Stomach Ulcers	
Hypertension		Gout		CHF		Hepatitis	
Hyperthyroidism		Fibromyalgia		Atrial Fibrillation		Fatty Liver	
Hypothyroidism		Sleep Apnea		PVD		NASH	
Goiter		Kidney Stones		Carotid Stenosis		Cirrhosis	
Calcium Disorder		Kidney Disorder		DVT		Pancreatitis	
Pituitary Disorder		Glaucoma		Neurological		Diverticulosis	
Osteoporosis		Psych / Misc		Migraine Headaches		Cancer	
PCOS		COPD		Stroke		Breast	
Erectile Dysfunction		Asthma		Seizures		Colon	
Vitamin D Deficiency		Anxiety		Dementia		Lung	
Bone Fracture		Depression		Neuropathy		Thyroid	

Family History

**Please list all family members with the following medical conditions:*

Condition	Year	Relationship
Heart Attack		
Hypertension		
High Cholesterol		
Calcium Disorder		
Cancer (Type):		
Stroke		
Diabetes Mellitus		
Osteoporosis		
Hyperthyroidism		
Hypothyroidism		
Kidney Stones		
Other:		
Other:		

Surgical Histroy

**Please list all previous surgeries, approximate date and location:*

Procedure	Year	Location
Carotid Stents / Surgery		
CABG		
Heart Stents		
Pacreatectomy		
Appendectomy		
Cholecystectomy		
Hernia Repair		
Thyroid Surgery		
Tonsillectomy		
Hysterectomy		
Tubal Ligation		
Transsphenoidal Surgery		
Other:		

Hospitalizations / Other Illnesses

**Please list all previous hospitalizations and major illnesses, with dates and reasons:*

Dates	Reason	Location

ENDOCRINE & DIABETES CLINIC

Diabetes Health History Form

General

In what year were you diagnosed with diabetes?	Whom were you diagnosed by?

How was your diabetes treated initially? ☐ Diet and Weight Loss ☐ Oral Medications ☐ Insulin ☐ Other

Please Explain:

How was diagnoses made? ☐ Elevated HbA1c ☐ OGTT ☐ Hospitalized ☐ Not feeling well ☐ Don't Know

Please Explain:

Have you had a recent measurement of your A1C? ☐ Yes ☐ No	Where was it done?	Value:

Medication Use History

What Diabetes Medications have you used in the past, but are <u>not</u> currently taking?

1)	2)	3)	4)

Why were these medications stopped? ☐ Ineffective ☐ Side Effects ☐ Change of Plan ☐ Other

If Other Reasons, please explain:

Current Insulin Injections

Dosing	Insulin - (Humalog, Novolog, Apidra, Lantus, Levemir, NPH, U 500, Other	Dosage - (*List the Range of Units Given Before Meals)
Early Morning		
Breakfast		
Lunch		
Dinner		
Bedtime		

* Correction Scale-Please describe how you cover a high blood glucose:

If you use insulin vials, who fills the syringe? ☐ Self ☐ Spouse/Significant Other ☐ Son/Daughter ☐ Parent ☐ Other

What injection sites are used? ☐ Stomach ☐ Arm ☐ Thigh ☐ Hip ☐ Buttock ☐ Other

Do you rotate your injection site? ☐ Yes ☐ No	Do you reuse your syringes? ☐ Yes ☐ No If yes, how often?
Where do you dispose of your syringes?	Do you have infections at the injection site? ☐ Yes ☐ No

How often do you forget or miss an insulin injection each day? ☐ 1x/day ☐ 2x/day ☐ 3x/day ☐ 1-2x/week

Which insulin dose are you most likely to miss? ☐ Basal ☐ Mealtime ☐ Don't know

What are you typically doing at the time you are likely to miss an injection?:

ENDOCRINE & DIABETES CLINIC

Diabetes Health History Form

Blood Sugar Testing

Do you have a glucometer (blood sugar testing device)? ☐ Yes ☐ No | What is the Name or Brand?

Do you test yourself? ☐ Yes ☐ No | How many times a day do you test? ☐ 1-2 ☐ 3+ ☐ Few times/wk ☐ Rarely

What target range do you try to keep your blood sugars between?

What are your usual fasting blood sugars? ☐ 70-120 ☐ 120-150 ☐ 150-200 ☐ >200

What are your usual post meal blood sugars? ☐ 80-150 ☐ 150-200 ☐ 200-300 ☐ >300

How would you rate your control over the years? ☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ Not Sure

Please Explain:

How would you rate your control over the past few weeks? ☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ Not Sure

Hypoglycemia

What do you consider a low blood sugar? | How often do you have low blood sugar, below 70?

☐ Daily ☐ Few times/week ☐ Once/week ☐ Few times/month ☐ Once in a while ☐ Never ☐ Not Sure

Do you feel different when your blood sugar is low? (Check all that apply)

☐ Sweaty ☐ Shaky ☐ Hungry ☐ Weak ☐ Pale ☐ Dizzy ☐ Irritable ☐ Trouble Concentrating

When is a low blood sugar most likely to occur? ☐ Morning ☐ After exercise ☐ After a missed meal ☐ Not Sure

How do you treat a low blood sugar that occurs? (Check all that apply) ☐ Adjust medicine dose ☐ Skip medicine

☐ Adjust Physical Activity ☐ Adjust Carb/Food intake ☐ Check Sugars More Often ☐ Call Healthcare provider

Have you ever had extremely low blood sugars causing unconsciousness? ☐ Yes ☐ No Explain:

Complications

Have you had any hospitalizations for high sugar or DKA since diagnoses? ☐ Yes ☐ No | When?

Have you ever had diabetic eye disease or previous laser treatment? ☐ Yes ☐ No | Provider:

When was your last dilated eye exam? | Where was it performed?

Have you ever had kidney problems or protein in your urine? ☐ Yes ☐ No | Comments:

Have you ever been diagnosed with diabetic neuropathy? ☐ Yes ☐ No | Comments:

Have you ever seen a foot doctor? ☐ Yes ☐ No | Have you ever had a foot sore or ulcer debrided? ☐ Yes ☐ No

Have you taken steroid medications in the last year? ☐ Yes ☐ No | ☐ Pills ☐ Injections ☐ Inhalers ☐ Creams ☐ Other

Do you take aspirin daily? ☐ Yes ☐ No Dose: | Have you had a flu shot during this flu season? ☐ Yes ☐ No

Have you had the Pneumonia Vaccine? ☐ Yes ☐ No Date: | Comments:

ENDOCRINE & DIABETES CLINIC

Patient Health Questionnaire

* Please complete and return to your nurse.*

Patient Name: _____ DOB: _____ Date: _____

1. Over the last 2 weeks, how often have you been bothered by any of the following problems?

Depression Screening (PHQ-9)	Not at all (0)	Several days (1)	More than half the days (2)	Nearly every day (3)
a. Little interest or pleasure in doing things	◯	◯	◯	◯
b. Feeling down, depressed, hopeless	◯	◯	◯	◯
c. Trouble falling / staying asleep, sleeping too much	◯	◯	◯	◯
d. Feeling tired or having little energy	◯	◯	◯	◯
e. Poor appetite or overeating	◯	◯	◯	◯
f. Feeling bad about yourself, or that you are a failure, or have let yourself or your family down	◯	◯	◯	◯
g. Trouble concentrating on things such as reading the newspaper or watching TV	◯	◯	◯	◯
h. Moving or speaking so slowly that other people have noticed. Or the opposite: being so fidgety or restless that you have been moving around more than usual	◯	◯	◯	◯
i. Thoughts that you would be better off dead or of hurting yourself in some way	◯	◯	◯	◯

_____ + _____ + _____ + _____

= _____

2. If you checked off any problem on this questionnaire so far, how difficult have these problems made it for you to do work, take care of things at home, or get along with other people?

◯ Not difficult at all ◯ Somewhat difficult ◯ Very difficult ◯ Extremely difficult

Have you fallen within the last 12 months? YES / NO If so, when and how? _____

Do you use tobacco? YES / NO / FORMER How long? _____ Amount? _____

Date of last Flu Vaccine? _____ Who gave your last Flu Vaccine? _____

Have you had a Pneumonia Vaccine? YES / NO If so, when? (mo / yr) _____

Have you had a COVID Vaccine? YES / NO If so, when? (mo / yr) _____

When was your last mammogram? _____ Where was it? _____

When was your last colonoscopy? _____ When is your next colonoscopy due? _____

Date of last eye exam? (mo / yr) _____

Endocrine & Diabetes Clinic, PLLC

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

(Important: All sections MUST be completed)

Patient: _____ Birth Date: _____

Address: _____ Phone: _____

_____ SSN: _____

RELEASE FROM: _____ RELEASE TO: _____

_____ _____

_____ _____

Specific type of information to be released:

□ Any / All Records □ Diagnostic Reports □ Lab Results □ Chart Notes □ Consultation Notes □ Operative Notes □ Other: _____

For date range: _____

(if no time period specified, records from only the previous 5 years will be released)

Purpose of Disclosure: □ Transfer of care – Reason: _____

□ Disability □ Worker's Comp □ Social Security □ Insurance

□ Attorney Request □ Other: _____

There is a minimum fee of $20.00 for the release of medical records which is the responsibility of the patient to pay prior to receiving the records. For records that exceed twenty (20) pages, there may be an additional charge of $0.50 per page for all pages exceeding the first twenty (20) pages. Please allow 7-10 business days to process all medical record requests.

I understand that my medical records may contain information **related to communicable diseases and infection information** as defined by statute and **Tennessee Department of Public Health Rules** (which include venereal disease "VD", tuberculosis "TB", Hepatitis (any form), Human Immunodeficiency Virus "HIV", Acquired Immunodeficiency Syndrome "AIDS" and AIDS Related Complex "ARC;" **alcohol and / or drug abuse treatment information** protected under regulation in 42 Code of Federal Regulations, Part 2; and **mental health records, psychological services** and / or **Social Services** information including communications made to or by a social worker, psychologist, or psychiatrist.

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Privacy Officer. I understand that the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire after five (5) years.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed as provided in CFR 164.524. I understand that any disclose of information carries with it the potential for an unauthorized redisclosure, and the information may not be protected by federal confidentiality rules. I understand that I may request a copy of this authorization. If I have questions about disclose of my health information, I may contact the Privacy Office at the disclosure location.

_____ _____

Signature of Patient or Legal Representative Date

_____

If Signed by Legal Representative, Relationship to Patient