Southeastern Endocrine & Diabetes, P.C.

1475 Holcomb Bridge Rd Ste 129
Roswell, Ga. 30076
Ph: 678-325-2250 Fax: 678-325-2261

____

Welcome to Southeastern Endocrine and Diabetes. You have the following appointment scheduled:

Date:____________________

With:____________________

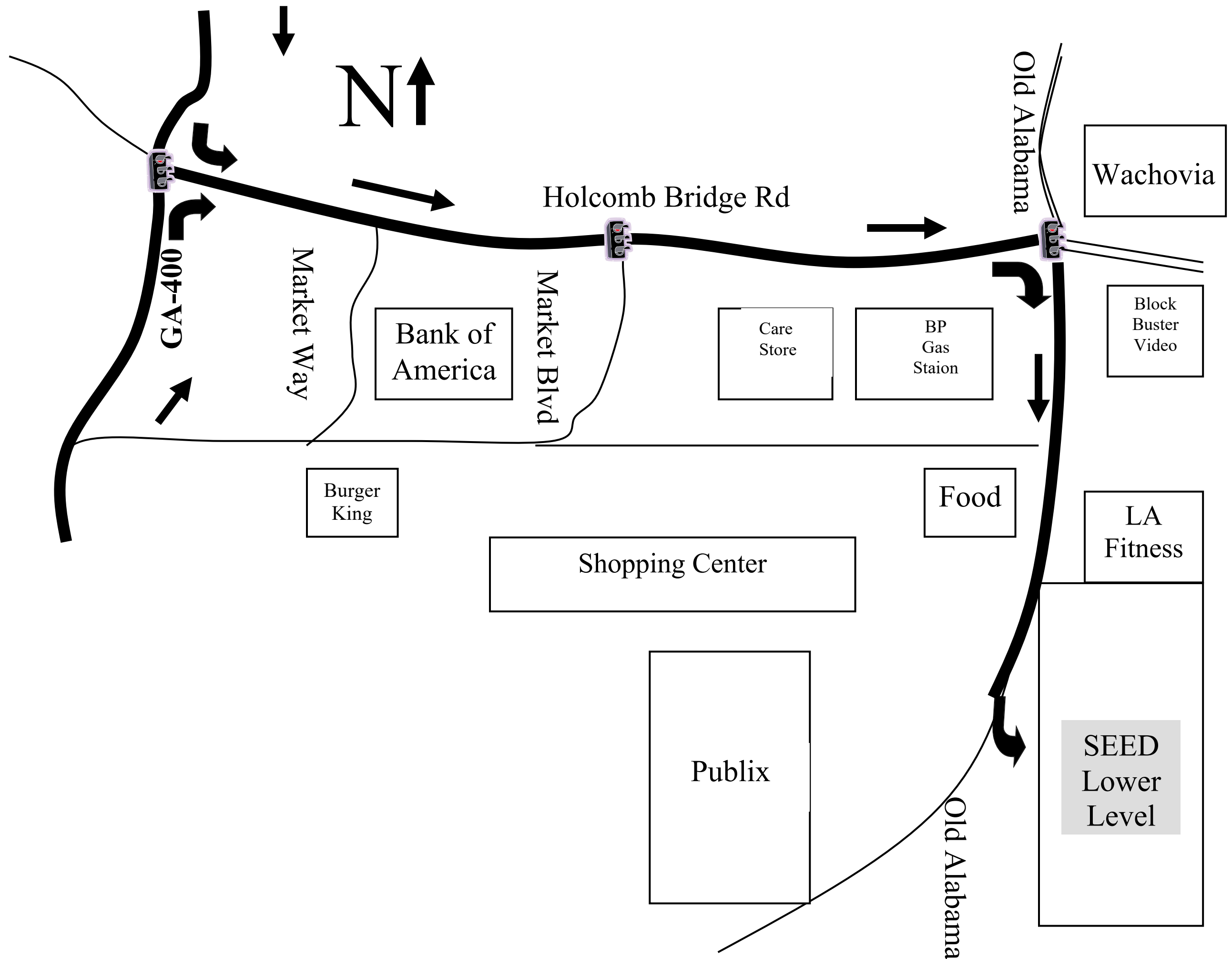
Listed below are ways to help us make your visit run smoothly. Please follow all directions.

- **Please be sure to fill out all paperwork pertaining to your visit and bring it with you to your scheduled appt. PLEASE DO NOT MAIL IN YOUR PAPERWORK!! Failure to have paperwork completed prior to your visit may result in rescheduling the appointment.**
- **Please arrive approximately 10 to 15 minutes early for your appointment to finish additional paperwork which needs to be completed in the office. IF YOU MUST CANCEL, WE REQUIRE 24 HOURS NOTICE, OR YOUR APPOINTMENT WILL BE CONSIDERED A NO SHOW APPOINTMENT. After 3 no show appointments your chart will be reviewed for possible dismissal.**
- **Please bring in your written referral with you IF Required from your Primary Care Physician or Insurance Co. – please note, you are responsible for keeping up with your referral status**
- **Please obtain and bring with you your last labs and office notes from your previous doctor or referring physician.**
- **Please call your insurance provider and confirm that our office is a network provider**
- **Please bring with you all current insurance information. Insurance cards are required.. Please have them with you upon arrival.**

Please keep in mind failure to follow any or all of the above suggestions could cause us to have to reschedule your appointment. We look forward to seeing you at your scheduled appointment time.

Thank You,
The Staff of Southeastern Endocrine & Diabetes, P.C.

Southeastern Endocrine & Diabetes, P.C.
Plaza 400 Shopping Center
1475 Holcomb Bridge Rd Ste 129
Roswell, Ga. 30076
Ph: 678-325-2250 Fax: 678-325-2261



Directions to the Office

Plaza 400 Shopping Center, 1475 Holcomb Bridge Road
Suite 129, Roswell, GA 30076
678-325-2250

From North
Drive South on GA-400
At exit 7 take Ramp and turn Left onto SR-140 (Holcomb Bridge Road) toward Norcross
At <u>second</u> traffic light turn Right onto Old Alabama
From there take the 3rd left and look for the sign **"Southeastern Endocrine & Diabetes"**

From South
Drive North on GA-400
At exit 7A take Ramp onto SR-140 (Holcomb Bridge Road) towards Norcross
At <u>second</u> traffic light turn Right onto Old Alabama
From there take the 3rd left and look for the sign **"Southeastern Endocrine & Diabetes"**

Very Important Patient Notice

Cancellations: Should you need to cancel an appointment; we ask that your give our office 24 hours notice. Failure to do so will result in a NO SHOW. A $50 charge will be added to your account in the event of a NO SHOW. Please be advised that after 3 (three) NO SHOWS your chart will be reviewed for possible dismissal from our practice.

Consent for Treatment: I consent to treatment necessary for the care of the patient named below.

Release of Medical Records: I authorize the release of all medical records to the referring and family physicians, and to my insurance company, if applicable. I authorize fax transmittal of my medical records if necessary.

Insurance Referrals: If my insurance requires a referral, I **WILL** have a referral on file prior to my visit as the appointment will be subject to cancellation without it. Please contact your PCP, and our office prior to your visit to be 100% sure your referral is in place. Lack of referral or claim denial as a result will lead to patient responsibility for their date of service.
POS: If you have POS insurance, your claim will be paid as out of network if you have not obtained an insurance referral.

Insurance Carriers: I understand that to protect myself from unnecessary personal financial losses, I must provide insurance coverage at time of registration, review my obligations with my insurance company, utilization review program, and personal physician without delay. Due to ever constant changes in insurance plans because of either physician participation or employer insurance changes, patients are responsible for making sure our providers are still participating with your insurance plans prior to each visit.

Redirection of Payment: I authorize electronic submission of my insurance claims. I authorize and request that insurance payment be made directly to Southeastern Endocrine & Diabetes PC, should they elect to receive such payments.

Financial Agreement: I acknowledge full responsibility for services rendered at Southeastern Endocrine & Diabetes PC. I understand that payment of the patient's co-payment and/or co-insurance/deductible is due at the time of service. I understand that if an unpaid balance is turned over to an outside agency for collection, I will be responsible for all cost of that collections. This includes a collection fee that will be added at 30% of the balance being placed in collections. It is also my responsibility to update my demographics and address on file as the main billing correspondence will be via mail.

Self-Pay (Uninsured Patients Only): All self-pay patient balances are due at time of services rendered.
All patient payments can be made via credit card, check, cash or on our website at seedreed.com.

I, ______________________________ hereby give Southeastern Endocrine & Diabetes, P.C. permission to
(Patient Name, please print)

release my Protected Health Information regarding medical treatment and/or financial accounting information to the following individuals:

☐ Medical Treatment ☐ Financial Account

Name of Authorized Person	Relationship
______________________________	____________________
______________________________	____________________
______________________________	____________________

X______________________________ ____________ ____________
Patient Signature Date of Birth Date

______________________________ ____________
Parent/Guardian Signature Date

PATIENT INFORMATION

Date ______________________

Name: ____ Sex: M F

Address: ______________________________ City, ST, Zip: ____________________

Date of Birth: __________ SSN: ______________ Marital Status: ______________

Home Phone: ______________ Work Phone: ______________ Cell Phone: __________

Employer: _____________________ Address: ______________________________

Emergency Contact: ____________________ Phone: ______________ Relationship: __________

PHARMACY INFORMATION

Pharmacy Name: ____________ Address: __________________________

City: ___________ Phone Number: ______________ Fax Number: ______________

PRIMARY CARE/REFERRING PHYSICIAN

Referring MD Name: ________________________ Phone Number: __________________

Address: ______________________________ City, ST, Zip: ____________________

PCP Name (if different): ______________________

GUARANTOR/SUBSCRIBER INFORMATION

Name (if different from above): ____

Address: ______________________________ City, ST, Zip: ____________________

Phone: ______________ Date of Birth: ______________ SSN: ______________

Employer: _____________________ Address: ______________________________

INSURANCE INFORMATION

**We will need to make a copy of your insurance cards in order to file your claims.*

	Primary Insurance	Secondary Insurance
Company:	______________________	______________________
Address:	______________________	______________________
Phone No.:	______________________	______________________
ID#:	______________________	______________________
Group #:	______________________	______________________
Subscriber:	______________________	______________________
Subscriber DOB:	______________________	______________________

X ____

Patient Signature/Legal Guardian (if patient is a minor) Date

MEDICAL HISTORY QUESTIONNAIRE

Today's Date ____________________

Patient Name ____ Date of Birth ____________________

Referred by ________________________________ Primary Care Physician ______________________________

Reason for Referral to Our Practice: ____

____

MEDICATIONS

Include prescribed & over-the-counter meds, vitamins, herbal supplements

Medication Name	Dosage (e.g. 10 mg)	Frequency Taken (e.g. 1 tab 3 times per day)

ALLERGIES & REACTIONS

please list drug names with allergic reactions or severe side effects

Drug	Reaction

MEDICAL HISTORY (List all significant past or present illnesses, medical conditions, injuries and accidents)

1.	6.	11.
2.	7.	12.
3.	8.	13.
4.	9.	14.
5.	10.	15.

SURGERIES

Year	Operation

HOSPITALIZATIONS

Year	Reason

FAMILY HISTORY

Condition	✓ if Yes	Which Relative?
Heart Disease		
High Blood Pressure		
Stroke		
Diabetes		
Hypothyroidism		
Hyperthyroidism		
Thyroid Nodules		

Condition	✓ if YES	Which Relative?
Thyroid Cancer		
Osteoporosis		
Hip Fracture		
Kidney Stones		
Obesity		
Alcoholism		
Mental Illness		

List the following information on your immediate family

Family Member	Living (L) Or Deceased (D)	Age at Death	Major Medical Problems	If Deceased, Cause of Death
Father				
Mother				
Brothers				
Sisters				
Maternal Grandmother				
Maternal Grandfather				
Paternal Grandmother				
Paternal Grandfather				
Sons				
Daughters				

SOCIAL HISTORY

Packs of cigarettes smoked per day ______________________________ number of years you have smoked ______________________

Amount of caffeinated soft drinks/coffee/tea per day ____

Amount and type of alcohol per week ____

Amount and type of exercise per week ____

Number of hours of sleep on an average night ____

Minimum and maximum body weight over the past 10 years (excluding pregnancy) ____________________________________

Place of Birth __________________________ Marital Status ________________________ # of Children ________________________

Highest level of education completed & degrees ____

Occupation/Employer ____

Recent stresses or major life changes ____

REVIEW OF SYMPTOMS

Please mark the box next to the symptoms which have been recurring or chronic

General
- ☐ Fever
- ☐ Fatigue
- ☐ Daytime sleepiness
- ☐ Difficulty Sleeping
- ☐ Weight Gain > 10 lbs
- ☐ Weight Loss > 10 lbs
- ☐ Loss of Appetite

Eyes
- ☐ Decreased Vision
- ☐ Blurred Vision
- ☐ Double Vision
- ☐ Peripheral Vision Loss
- ☐ Color Blindness
- ☐ Eye irritation
- ☐ Dry eyes
- ☐ Red Eye
- ☐ Excessive tearing
- ☐ Eyelid Swelling
- ☐ Protruding Eyes

Ears, Nose, Throat
- ☐ Sinus pain
- ☐ Sore throat
- ☐ Dry Mouth
- ☐ Dental Problems
- ☐ Difficulty Hearing
- ☐ Nasal Congestion
- ☐ Pain in front of Neck
- ☐ Change in neck size
- ☐ Choking sensation
- ☐ Hoarse Voice
- ☐ Deepening of the Voice
- ☐ Loss of Smell

Pulmonary
- ☐ Cough
- ☐ Wheezing
- ☐ Snoring
- ☐ Sleep Apnea
- ☐ Shortness of breath

Cardiovascular
- ☐ Chest Pain
- ☐ Palpitation
- ☐ Gasping for air at night
- ☐ Out of breath lying flat
- ☐ Leg swelling
- ☐ Leg Pain with Walking
- ☐ Blue Fingers or Toes
- ☐ Dizziness with standing
- ☐ Fainting

Gastrointestinal
- ☐ Abdominal Pain
- ☐ Nausea
- ☐ Vomiting
- ☐ Constipation
- ☐ Diarrhea
- ☐ Frequent Stools
- ☐ Bloating
- ☐ Feeling Full Quickly
- ☐ Excessive Belching
- ☐ Difficulty Swallowing
- ☐ Gluten Intolerance
- ☐ Lactose Intolerance
- ☐ Black Stool
- ☐ Blood in Stool

Urinary System
- ☐ Frequent Urination
- ☐ Urination at Night
- ☐ Pain with Urination
- ☐ Leakage of Urine
- ☐ Difficulty starting stream
- ☐ Dribbling after urination
- ☐ Blood in Urine

Musculoskeletal
- ☐ Muscle Pain
- ☐ Muscle Weakness
- ☐ Joint Pain
- ☐ Joint Swelling
- ☐ Bone Pain
- ☐ Back Pain
- ☐ >1 inch Loss of Height
- ☐ Size of Hands change
- ☐ Shoe Size Change

Skin
- ☐ Nail Changes
- ☐ Itching
- ☐ Dry Skin
- ☐ Rashes
- ☐ Acne
- ☐ Excessive Scalp Hair loss
- ☐ Receding Hair line
- ☐ Excessive Body Hair
- ☐ Excessive Facial Hair
- ☐ Change in Skin Color
- ☐ Purplish Stretch Marks
- ☐ Easily Bruised
- ☐ Thinning of the skin
- ☐ Hives
- ☐ Frequent Skin Infections
- ☐ Slow Healing

Endocrine
- ☐ Excessive thirst
- ☐ Excessive hunger
- ☐ Craving for sugar
- ☐ Craving for salt
- ☐ Intolerance to cold
- ☐ Intolerance to heat
- ☐ Excessive sweating
- ☐ Trouble losing weight

Neurological
- ☐ Headache
- ☐ Numbness/Tingling
- ☐ Burning in hands/feet
- ☐ Paralysis
- ☐ Memory Loss
- ☐ Mental fogginess
- ☐ Hand Tremors
- ☐ Seizures

Female Reproductive
- ☐ Hot Flashes
- ☐ Vaginal Dryness
- ☐ Low Sexual Desire
- ☐ PMS
- ☐ Irregular Menstrual Period
- ☐ Breast Milk Discharge
- ☐ Breast Lumps/pain

Male Reproductive
- ☐ Shrinking Testicular size
- ☐ Decreased shaving Frequency
- ☐ Low sexual drive
- ☐ Hot flashes
- ☐ Difficulty initiating erection
- ☐ Difficulty keeping erection
- ☐ Inability to ejaculate
- ☐ Breast growth
- ☐ Milk discharge from nipples

Psychiatric
- ☐ Anxiety
- ☐ Depressed Mood
- ☐ Inability to feel pleasure
- ☐ Mood Swings
- ☐ Irritability
- ☐ Apathy, lack of drive
- ☐ Difficulty concentrating
- ☐ Guilty Feelings
- ☐ Insomnia
- ☐ Nightmares
- ☐ Thoughts of Suicide

DIABETES QUESTIONNAIRE

Patient Name ______________________________ Date ____________________

Diabetes Diagnosis

When were you diagnosed as having diabetes? ____________ Body weight at diagnosis (lbs/Kg)? ____________

What was your blood glucose level or Hba1c at diagnosis? ______________________________

What symptoms did you have (e.g. urination, thirst, weight loss)? ______________________________

Diabetes Complications

Eye problems (diabetic retinopathy)? No Yes ______________________________

Nerve problems (diabetic neuropathy)? No Yes ______________________________

Kidney problems (diabetic nephropathy)? No Yes ______________________________

Heart problems, stroke, or blood vessel blockages? No Yes ______________________________

Hospitalizations for Diabetes? No Yes ______________________________

Date of Last Dilated Exam: ____________________

Followed by Podiatrist? No Yes ____________________

Diabetes Treatment

What treatment did you receive initially (e.g. pills, insulin)? ______________________________

Describe any changes: Year: __________ Change: ______________________________

Year: __________ Change: ______________________________

Year: __________ Change: ______________________________

Year: __________ Change: ______________________________

If you are insulin, what year did you start taking insulin? ____________

Please list the diabetes meds that you currently take, including dose & frequency: ______________________________

____

Glucose Monitoring

How often do you monitor your sugar? ______________________________

Average Glucose results past month (e.g. 80-150)? ______________________________

What have your Hba1c results been over the past few years (e.g 6-8%) ____________

Diet and Exercise Pattern

Describe the diet you were given for your diabetes (calorie intake, salt restriction, protein restriction, meals, snacks) and how well you maintain it? ______________________________

Describe any exercise you do on a regular basis? ______________________________

____

What are your daily eating habits (number and content of meals, snacks)

____

____

Diabetes Education, Knowledge

Describe any previous diabetes education you have had ______________________________

____

Are you familiar with the following topics?

	Yes/No	Questions
Administering Insulin	________	______________________________
Ketone testing	________	______________________________
Home Glucose Monitoring	________	______________________________
Glucose targets & Hba1c goals	________	______________________________
Sick Day Management	________	______________________________
Complications of Diabetes	________	______________________________
Foot Care	________	______________________________

What concerns, questions or feelings do you have regarding your diabetes?

____

____

THYROID QUESTIONNAIRE

Patient Name ____ Date ______________

Do you have a history of a diagnosed thyroid problem? ______________________________
(*If No to above, please skip remainder of thyroid questionnaire*)

Diagnosis of Thyroid condition
What thyroid condition do you have? ______________________________
When were you first diagnosed with a thyroid problem (mo & yr)? ______________________________
What symptoms did you have at diagnosis? ______________________________
____

Thyroid Labs and Ultrasounds
What were the thyroid lab results at diagnosis (e.g. TSH)? ______________________________
Have you had a Thyroid Ultrasound performed in the past? __________ Date of last Thyroid Ultrasound __________
Results of last thyroid ultrasound (e.g. goiter, nodule size) ______________________________
Thyroid Medication
Have you ever taken thyroid medication? ______ When? ________ What Type?______________
How do you take your thyroid medication (e.g. morning, empty stomach, bedtime)? ______________________________

Thyroid Procedures
If you have had a prior Thyroid FNA biopsy, list dates & pathology result______________________________
If you have undergone thyroid surgery, please include date of surgery and hospital ______________________________
If you received Radioactive iodine, please provide date, dose, and treatment location: ______________________________

Thyroid Cancer History
If you have a history of thyroid cancer, please indicate the type (papillary, follicular, hurthe cell) ______________
Prior history of lymph node metastases? ______________________________

Questions or Concerns Regarding your thyroid condition? ______________________________
____

MENSTRUAL HISTORY QUESTIONNAIRE

Please describe your menstrual periods
Age when Periods Began __________ Date of last Period ______________
Frequency of Periods (e.g. every 28-35 days) ____________ Avg # of periods missed per year ______________
Duration of Bleeding ____________ Amount of Flow ______________
Other symptoms with period (cramps, etc) ______________________________

Describe the following about your pregnancies

	Number of	Dates and other details
Pregnancies		
Premature Babies		
Miscarriages		
Abortions		

List Any other Complications of Pregnancies ______________________________
Please answer the following questions regarding hysterectomy/menopause

Date and reason for hysterectomy ______________________ Were the ovaries removed? ______
Any vaginal bleeding after the periods ended? ______________________________

If you are currently taking or have taken female hormones or birth control, please answer the following:

Name of hormone (s) you are/were on ______________________________
When did you start? ______________________________
How long did you take it? ______________________________
Side effects, if any ______________________________
What symptoms did the hormones help, if any? ______________________________
Date of last mammogram? __________