Diabetes and Endocrine Associates

DIPLOMATES INTERNAL MEDICINE AND ENDOCRINOLOGY

DANIEL EINHORN, M.D.
(858) 622-7200
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KARLA D. CABRERA, PA-C
(760) 337-8803
FAX (760) 337-5970

LAST NAME: ______________________ FIRST NAME: ______________________

STREET ADDRESS: ______________________ CITY: ______________

STATE: ________ ZIP: ____________ SEX :M ________ F ________ SSN: ______________________

DATE OF BIRTH: ______/______/______ MARITAL STATUS: S____M____D____W____

HOME #(   ) ______________ CELL #(   ) ______________ WORK#(   ) ______________

WHO REFFERED YOU: ______________________

PRIMARY CARE PHYSICIAN: ______________________

NAME/PHONE NUM OF NEAREST RELATIVE: ______________________

DO WE HAVE PERMISSION TO LEAVE ANY RESULTS ON ANSWERING MACHINE? ______________

ANY RESTRICTIONS? ______________________

IT IS OPTIONAL TO GET RESULTS BY E-MAIL, IF THAT IS YOUR PREFERENCE PLEASE DISCLOSE

E-MAIL ADDRESS: ______________________

INSURANCE INFORMATION

NAME OF INSURANCE: ______________________

SECONDARY, IF ANY? ______________________

NAME AND SOCIAL OF PRIMARY SUBSCRIBER OF INSURANCE, IF NOT YOURSELF:

I HEARBY AUTHORIZE MY INSURANCE TO PAY DIRECTLY TO DIABETES AND ENDOCRINE ASSOCIATES, BENEFITS DUE ME OUT OF INDEMNITY UNDER THE TERMS OF MY POLICY ISSUED BY THE INSURANCE COMPANY. PAYMENT IS DUE UPON RECEIPT OF AN ITEMIZED STATEMENT FOR SERVICES RENDERED. PAYMENT OF THIS AMOUNT HEREIN DIRECTED, IN WHOLE, IN PART, SHALL BE CONSIDERED THE SAME AS IF PAID TO ME DIRECTLY BY YOUR COMPANY.

LEGAL SIGNATURE: ______________________ DATE: ______________

LIST ANY ALLERGIES & SENSITIVITIES/TYPES OF REACTION TO MEDICATIONS:

DIABETES & ENDOCRINE ASSOCIATES MEDICAL GROUP, INC.

CONSENT OF DISCLOSURE

PATIENT______________________________

PHYSICIAN RAYMOND I. FINK, M.D.

In connection with the medical services that I am receiving from the above named physician or physician, I hereby authorize the above named physician and/or group to disclose any and all information concerning my medical condition and treatment, including copies of applicable hospital and medical records to:

A. Any third party payer covering the medical services of the patient;

B. Other health care professionals and institutions involved in the delivery of health care to the patient;

C. The proponent of any legally sufficient subpoena, or in response to a court order;

D. Employees and agents of the practice, to the degree necessary to facilitate the provision of health care services and payment for such services;

E. Pharmacies;

F. Employees and agents of the research division, to the degree necessary to identify and determine eligibility for clinical research trials; and

G. Other parties as otherwise required by law.

In each case the practice shall take reasonable steps to ensure that only the minimum necessary information is disclosed in accordance with the above. I further understand that I have been given access to the physician's privacy notice and that I have had the opportunity to place special restrictions upon the consent hereby given.

Special Restrictions:____

____

This consent is valid from the date executed until revoked in writing by the patient.

Signed:______________________________

Date:______________________________

Witness:______________________________

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CONSET OF DISCLOSURE

PATIENT_______________________________

PHYSICIAN______ RAYMOND I. FINK, M.D. ______

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____

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Signed:____

Date:____

Witness:____

AUTHORIZATION FOR RECORDS RELEASE

TO____

ADDRESS____

I hereby authorize and direct you to release to:

DIABETES & ENDOCRINE ASSOCIATES
RAYMOND I. FINK, M.D.

8851 Center Drive, Suite 404
La Mesa, California 91942
Telephone: (619) 463-1293 FAX: (619) 463-8230

The complete medical records in your possession relative to my illness and/or treatment during the period from ______________ to ______________

NAME______________________________ DATE____________

ADDRESS____

SIGNATURE_______________________ WITNESS____________
(IF RELATIVE, STATE RELATIONSHIP)

Diabetes and Endocrine Associates Financial Policy

Thank you for your attention to this. Please let us know if you have any questions.

1. Co-Payments: Co-payments are due at the time of check-in for your appointment. Our office accepts cash, personal checks, and credit cards.

2. Missed Appointments: If you have to reschedule your appointment, we need you to call us at least 24 hours before your appointment time so that we can schedule another patient from the waiting list. When you reschedule, please be sure to note the new time and date.

3. Insurance Cards: Your insurance card and complete insurance information is required at the time of each and every visit because these things change so often. If that is not possible, to avoid problems in billing, please provide us this information within 24 hours of your appointment. This information needs constant updating, and failure to do so is responsible for many misunderstandings.

4. Insurance Policies:

Contracted and in-network: As a courtesy, we will bill your primary and secondary insurance policies. However, you are ultimately responsible for payment of services not covered by your insurance plan. It is your responsibility to call and check with your insurance as to which services are covered.

Non-contracted insurance companies and out-of-network: If we are not contracted with your insurance company or have out-of-network benefits, payment is still due in full at the time of service. We will provide you with a copy of your completed charge ticket so that you may file with your own insurance company directly. This change in policy is due to the confusion that has occasionally occurred when CHMB has filed claims for individuals.

By signing below, you agree that you understand and will abide by the above described financial policy. Thank you again.

__________________________ ________________________ __________

Print Name Signature
Date

REVISED 4/1/12

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Thyroid and Metabolism Questionnaire

Do you have a thyroid problem?________ If so, for how long?________________
What kind of problem do you have?______________________________________

____

Do your have a goiter? (Big thyroid gland)?_______________________________
Do you have a lump or module?________ If so, for how long?________________
Have your ever been treated with radiation as a child?_______________________
Have you ever had a thyroid operation?_________ If so, when?_______________
Do you take thyroid medications?____________ If so, what kind and how much?____
Does anyone in your family have a thyroid problem?_________________________
If so, who and what kind of problem is it and what treatment are they receiving?______

____

____

Do you have any of the following?
Weight gain?_______ Weight loss?_______ Please give details_________________

____

Shaking?________ Heat or cold intolerance?_________ Palpitations?___________
Change in bowel movements?_________ Change in skin texture?_______________
Hair loss?_______ Eye discomfort?_______ Muscle weakness or cramping?________

Have you ever been a patient in the hospital?_________
If yes, when and for what reasons?_______________________________________

____

Do you smoke?_________ If so, how much and for how long?_________________
If you smoked in the past, how much and when did you quit?__________________
Do you exercise?_________ If so, how much and for how long?________________
Do you drink alcohol?_______ If so, how much per week/day?_________________
Do you or have you used any other drugs?)______________________________
Do you know your cholesterol?_________ If so, is it high or normal?____________
List your current medications and doses used:_____________________________

____

____

9850 Genesee Avenue • Suite 415 • La Jolla, California 92037

1594 S. Imperial • Suite A • El Centro, California 92243

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For women only:

Are you still having menstrual cycles?_______ Are they regular?________________
Date of last menstrual period?)________________________________
How many pregnancies have you had?____________________________
How many children do you have?______________________________
When was your last Pap smear?_______________________________
When was your last mammogram?_____________________________

Are you having problems with any of the following?

Sleeping?__________ Emotions?__________ Irritability?________________
Depression?_________ Episodes of crying or sadness?____________________
Fatigue?____________ Memory?__________________________________
Motivation or organization?___________________________________
Desire to socialize with friends or family?_________________________

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