Southern Endocrinology Associates P.A
Patient Information

Referred By:______________ PCP:______________ Date:__/__/___

Name:_______________________________________ Gender: F M
(Last) (First) (M)

DOB:__/__/___ Ethnicity:____________ Language:_____________

Address: ______________________ City: _____________ State: _____

Zip code: ________ Email:_________________________________

Home Number : (___)-___-_____ Cell Number : (___)-___-_____

Work Number : (___)-___-_____ EXT: ______ Marital Status: ______

Driver License #: ________________ Social Security # ___-__-_____

Emergency Contact:____________________ Phone #: (___)-___-___

Primary Insurance: _________________________

Secondary Insurance: _________________________

Name of Insured: _________________________ DOB: ___/___/_____

If we are unable to contact you, please provide us with a phone number where we can leave a detailed message regarding labs, etc...

Phone #:(___)-___-___ Initials: ______

Pharmacy: _______________ Street: _________________________

City: ______________ State: ______ Phone #: (___)-___-_____

Assignment of benefits
I authorize payment of benefits to the Names Provider for professional services rendered.

Release of Information
I authorize the release of any medical Information necessary to process this claim.

Signed: __________________ Date__/__/__ Signed:_________________ Date: __/__/__

Southern Endocrinology & Diabetes Associates PA

Sumana Gangi, M.D	Dr.Bontha M.D	Sreedevi Guttikonda. M.D
1621 N. Beltline Rd.	9330 Poppy Dr.	7801 LakeView pkwy
Suite A.	Suite #500	Suite # 110
Mesquite, Tx 75149	Dallas, TX 75218	Rowlett, Tx 75088

Statement of financial obligation

All payments are expected at the time of service.

This office is contracted with many different insurance plans, we will be happy to file your insurance claims, however, you will be expected to pay your co-payment, deductible, and/or co-insurance at each visit. We accept cash, check or master/ visa card.

Statement of benefits obligation

All patients are expected to provide our office with current insurance information and to understand their benefits.

For the convenience of our patients our provider participates in a variety of managed care plans. Our office also acts as an advocate for our patients with their managed care plans. This may include completing pre-certifications, eligibility verifications or similar paper work on behalf of the patient. Ultimately, the patient is responsible for understanding their benefits and providing our office with current information so that we can handle this paperwork on their behalf in a timely manner.

Referral from primary care physician

If you are required by your insurance to have a referral from the primary care physician to see us this must be done prior to the appointment. Otherwise you will be directly responsible for the service rendered.

Our mission as a practice is to provide for the health and well being of our patients. Your health insurance is a contract between you and your health insurance company. You are financially responsible for any non-covered services.

I hereby authorize Southern Endocrinology Associates P.A/ Sumana Gangi, M.D and Sreedevi Guttikonda, M.D. to apply for benefits on my behalf for covered services rendered by her order. I request that payment by my insurance company be made directly to Dr. Gangi/ Southern Endocrinology Associates P.A. or by the party who accepts assignment. I certify that all information I have reported with regards to my insurance information is correct. I also authorize the use of this signature on all of my insurance submission.

______________________________ _______________

Signature of patient/ responsible party Date

Southern Endocrinology
& Diabetes Associates PA

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Consent for use and disclosure of health information

I hereby permit Southern Endocrinology Associates to release and furnish all medical and financial date related to my care that may be necessary now or in the future for purposes of treatment, payment or health care operations to assist with, and in, or facilitate the collection of data purposes of utilization to review, quality assurance, or medical outcomes evaluation purposes. Such information may be released to insurance company, **HMO's** and **PPO's**, managed care organizations, **IRA's, Medicare/Medicaid.** Or other governmental or third party payers, or organization contracting with any of the above entries to perform such functions.

The notice of privacy practices issued by Southern Endocrinology Associates provides specific information and complete description of how my personal health information may be used and disclosed. I have been provided a copy of our access to **THE NOTICE OF PRIVACY PRACTICES** and understand that I have the right to review the notice prior to signing this consent. If this consent is revised in the future, I may obtain a revised copy from the office.

I have the right to request at the office to restrict uses and disclosure of my health information. However this office is not required to agree to a requested restriction. I have the right to revoke this consent in writing to the extent this office has previously taken action in reliance on this consent. My treatment by this office is conditional upon signing this consent.

____
Patient Signature

Southern Endocrinology

&Diabetes Associates PA

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AUTHORIZATION TO RELEASE MEDICAL INFORMATION

- I AUTHORIZE INFORMATION TO BE RELEASED TO DESIGNEES
- MOTHER____
- FATHER ____
- SON ____
- DAUGHTER ____
- OTHER ____
- I DON'T WISH TO HAVE ANY INFORMATION RELEASED TO ANYONE BUT MYSELF.

_________________________ ___/___/____

PATIENT SIGNATURE DATE

Southern Endocrinology &Diabetes Associates PA

Name:______________________________

Current Medication List with Dosages

1. ______________________________	**11.** ______________________________
2. ______________________________	**12.** ______________________________
3. ______________________________	**13.** ______________________________
4. ______________________________	**14.** ______________________________
5. ______________________________	**15.** ______________________________
6. ______________________________	**16.** ______________________________
7. ______________________________	**17.** ______________________________
8. ______________________________	**18.** ______________________________
9. ______________________________	**19.** ______________________________
10. ______________________________	**20.** ______________________________

If you have a list please attach.

Thank you !

Medical History:

____

____

____

Drug Allergies:

____

____

____

Hospitalizations:

____

____

____

Surgeries:

____

____

____

Patient Name: ______________________________ Date: __/__/_____

Past Medical History:

ASTHMA	O YES	O NO
DIABETES	O YES	O NO
HYPERCHOLESTROLEMIA	O YES	O NO
COPD	O YES	O NO
ARTHRITIS	O YES	O NO
DEPRESSION	O YES	O NO
HEART FAILURE	O YES	O NO
HIGH BLOOD PRESSURE	O YES	O NO
STROKE (THOMBOTIC)	O YES	O NO
OBESITY	O YES	O NO
BACK PAIN	O YES	O NO
SLEEP APNEA	O YES	O NO
CANCER	O YES	O NO
GERD/reflux	O YES	O NO
CAD	O YES	O NO
HEPATITIS C	O YES	O NO
CIRRHOSIS	O YES	O NO
CHRONIC STEROID USE	O YES	O NO
KIDNEY PROBLEMS	O YES	O NO

Social History:

SMOKING: O YES O NO

MARITAL STATUS: O MARRIED O SINGLE O WIDOWED O DIVORCED

ALCOHOL: O YES O NO

ILLICIT DRUG USE: O YES O NO

Family History:

MOTHER: O DIABETES O HYPERTENSION O HEART PROBLEM O CANCER O HIGH CHOLESTEROL

FATHER: O DIABETES O HYPERTENSION O HEART PROBLEM O CANCER O HIGH CHOLESTEROL

SIBLINGS: O DIABETES O HYPERTENSION O HEART PROBLEM O CANCER O HIGH CHOLESTEROL

OTHER: O DIABETES O HYPERTENSION O HEART PROBLEM O CANCER O HIGH CHOLESTEROL

Patient Name: ___________________________ **Date:** __/__/_____

CONSTITITIONAL:		
FEVER	O YES	O NO
CHILLS	O YES	O NO
THIRST	O YES	O NO
FATIGUE	O YES	O NO
WEIGHT GAIN	O YES	O NO
INSOMNIA	O YES	O NO
TIREDNESS	O YES	O NO
ENDOCRINOLOGY		
EXCESSIVE URINATION	O YES	O NO
SENSITIVE TO COLD TEMPERATURE	O YES	O NO
SENSITIVE TO HO TEMPERATURE	O YES	O NO
BEAST TENDERNESS	O YES	O NO
BREAST DISCHARGE	O YES	O NO
POOR LIBIDO	O YES	O NO
ENT		
TINNITUS	O YES	O NO
ALLERGIES	O YES	O NO
PERSISTENT HOARSNESS	O YES	O NO
DECREASED HEARING	O YES	O NO
NASAL DISCHARGE	O YES	O NO
EARACHE	O YES	O NO
EYE		
CATARACT	O YES	O NO
DECREASED VISION	O YES	O NO
CORRECTIVE LENS	O YES	O NO
DRY EYES	O YES	O NO
RETINOPATHY	O YES	O NO
LASER TREATMENT	O YES	O NO
GLAUCOMA	O YES	O NO
HEME		
EASY BRUISING	O YES	O NO
CARDIAC		
CHEST PAIN OR PRESSURE	O YES	O NO
PALPITATIONS	O YES	O NO
LEG SWELLING	O YES	O NO
SHORTNESS OF BREATH	O YES	O NO
HIGH BLOOD PRESSURE	O YES	O NO
CLAUDICATION	O YES	O NO

Patient Name: ___________________________ Date: __/__/____

GASTROINTESTINAL

NASUEA	O YES	O NO
HEARTBURN	O YES	O NO
ABDOMINAL PAIN	O YES	O NO
VOMITING	O YES	O NO
DIARRHEA	O YES	O NO
CONSTIPATION	O YES	O NO

NEUROLOGIC

FREQUENT HEADACHE	O YES	O NO
TINGLING	O YES	O NO
TREMOR	O YES	O NO
NUMBNESS	O YES	O NO
MIGRAINES	O YES	O NO
BURNING PAIN IN FEET	O YES	O NO
LANCINATING PAINS IN FEET	O YES	O NO
VERTIGO	O YES	O NO
SCIATICA	O YES	O NO

DERMATOLOGY

EXCESSIVE DRY SKIN	O YES	O NO
HAIR LOSS	O YES	O NO
ACNE	O YES	O NO
PLANTAR WART	O YES	O NO
DRY SKIN	O YES	O NO
ITCHING	O YES	O NO
SKIN ULCER	O YES	O NO
VITILIGO	O YES	O NO
LESIONS	O YES	O NO

URINARY MALE

DYSURIA	O YES	O NO
NOCTORIA	O YES	O NO
FREQUENCY	O YES	O NO
PENILE DISCHARGE	O YES	O NO
DIFFICULTY URINATING	O YES	O NO

GYNECOLOGICAL

AMMENORHEA	O YES	O NO

ALLERGY

DRUG ALLERGIES (listed elsewhere)	O YES	O NO
SINUS CONGESTION	O YES	O NO
EAR FULLNESS	O YES	O NO

PHYCHIATRIC

DEPRESSION	O YES	O NO
HIGH STRESS LEVELS	O YES	O NO
SLEEP DISTURBANCES	O YES	O NO
EATING DISORDER	O YES	O NO
SUICIDAL IDEATION	O YES	O NO