Arizona Diabetes & Endocrinology, PLC ~Shabeena Shaik, MD
Raquel Castaneda, FNP-BC, CDE ~Julie Linn, PA-C ~Mami Trollope, MSN, AGNP-C
3489 S. Mercy Road, Suite 101, Gilbert, AZ 85297 Phone (480) 646-8433 Fax (480) 646-8434 www.azdne.com

PERSONAL HEALTH HISTORY INFORMATION

All questions contained in this questionnaire are strictly confidential and will become part of your medical record

Name:	**DOB:**
Referring Doctor:	**PCP:**
Reason for visit:	

Preferred Pharmacy: (if No Pharmacy Used, Please List A Pharmacy Near Your Place of Residence)

Local Pharmacy Name:	Address or Cross Streets:	Phone/Fax:
Mail Order Pharmacy:	Phone:	Fax:

Preferred Lab and Imaging: (if Unknown, Please Contact your Insurance Plan for Contracted Lab and Imaging)

Lab: □ Sonora Quest □ LabCorp □ Other (List Name):
Imaging: □ SimonMed □ SMIL □ Banner Imaging □ Other (List Name):

Medications and Supplements: □ Check Here if No Current Medications or Supplements

Drug Name	Dose	How Many Times A day

Allergies: (Please List Reaction If Applicable) □ Check Here if No Current Allergies

Immunizations: □ Check Here if No Recent Vaccinations □ Check Here for Vaccine Refusal

Influenza Vaccine	**Date Vaccinated:**
Pneumonia Vaccine	**Date Vaccinated:**
Other: (COVID-19)	**Date Vaccinated:**

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Past Medical Conditions: □ Check Here if No Past Medical Conditions

□ Anxiety	□ Coronary Artery	□ Hyperlipidemia (Elevated	□ Muscle, Joint, Bone
□ Arthritis	□ Depression	□ Hypertension (Elevated Blood Pressure)	□ Obesity
□ Asthma	□ Diabetes	□ Hyperthyroidism	□ Osteoporosis
□ Birth Defects/Inherited	□ Fibromyalgia	□ Hypothyroidism	□ PCOS
□ COPD	□ Gout	□ Kidney Disease	□ Pituitary Disorder
□ Cancer Type:	□ Heart Disease	□ Liver Disease	□ Stroke
□ Thyroid Problem Type:		□ Other:	

Prior Surgeries: (Please List Date/Year If Applicable) □ Check Here if No Past Surgeries

Recent Hospitalizations: (Please List Reason, Date, Hospital Name and Location) □ Check Here if No Recent Hospitalizations

Diabetes Examination: □ Check Here if No Diabetes Examination Has Been Performed Previously

Exam	Provider's Name/Practice	Address or Cross Streets	Phone and Fax
Eye Exam			
Foot			

Diabetic Supplies: * Diabetic Patients' Only *****

Glucometer:	Test Strips:	Lancets:	Other:
Insulin Pump:	Infusion Set:	Reservoir:	Catridges:
DME Company Providing Supplies:			
Continuous Glucose Monitor (CGM):	Reader/Receiver:	Censors:	Transmitter:
DME Company Providing Supplies:			

Did you bring any of the following with you today? (Please Check)
□ Blood Sugar Meter □ Log Book □ Insulin pump
Please bring your meter, log book, insulin pump and medication list to **all future appointments.**

Family History: □ Check Here if No Family History □ Check Here if Adopted and Unknown

Condition	Relation
□ Celiac Disease	□ Paternal □ Maternal
□ Cancer	□ Paternal □ Maternal

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□ Diabetes Mellitus	□ Paternal □ Maternal
□ High Cholesterol	□ Paternal □ Maternal
□ Heart Disease	□ Paternal □ Maternal
□ Hypertension	□ Paternal □ Maternal
□ Hip Fracture	□ Paternal □ Maternal
□ Iron Overload Disease	□ Paternal □ Maternal
□ Obesity	□ Paternal □ Maternal
□ Osteoporosis	□ Paternal □ Maternal
□ Premature Menopause	□ Paternal □ Maternal
□ Pancreatic Tumor or Cancer	□ Paternal □ Maternal
□ Pituitary Tumor or Cancer	□ Paternal □ Maternal
□ Stroke	□ Paternal □ Maternal
□ Seizure	□ Paternal □ Maternal
□ Thyroid Disease	□ Paternal □ Maternal
□ Thyroid Cancer	□ Paternal □ Maternal
□ ParaThyroid / Calcium Problem	□ Paternal □ Maternal
□ Pheochromocytoma	□ Paternal □ Maternal

Previous History of Steroid Use: (Oral, Injections, Inhaled, Topical) □ Check Here if No Previous History of Steroid Use

Social History:

Tobacco	□ Never Smoker □ Former Smoker □ Current Every Day Smoker □ Current Some Day
Smoking How Much	□ 1 Pack Per Week □ 2 Packs Per Week □ ¼ Pack Per Day □ ½ Pack Per Day □ 1 Pack Per Day □ 1 ½ Pack Per Day □ 2 Packs Per Day □ 3+ Packs Per Day
Smokeless	□ Never □ Former □ Current Snuff User □ Currently Chews Tobacco □ Current Moist
E-Cigarette/Vape	□ Never □ Current User □ Former User

Review of Systems: (Please Mark All Current Symptoms That Apply)

Constitutional:			
□ Fever	□ Night Sweats	□ Weight Gain / How Much:	□ Weight Loss / How Much:
□ Exercise Intolerance	□ Lethargy	□ Chills	□ Malaise (General Discomfort)
Eyes:			
□ Dry Eyes	□ Irritation	□ Vision Change	□ Eye Disease / Injury
Nose:			
□ Frequent Nose	□ Nose Problems	□ Sinus Problems	
Mouth/Throat:			
□ Sore Throat	□ Bleeding Gums	□ Snoring	□ Dry Mouth
□ Oral Abnormalities	□ Mouth Ulcers	□ Teeth Abnormalities	□ Mouth Breathing
□ Ringing in Ears	□ Sinusitis		

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Cardiovascular:			
□ Chest Pain on Exertion	□ Arm Pain on Exertion	□ Shortness of Breath When Walking	□ Shortness of Breath While Laying Down
□ Palpitations	□ Known Heart Murmur	□ Light Headed on Standing	□ Ankle Swelling
Respiratory:			
□ Cough	□ Wheezing	□ Shortness of Breath	□ Coughing Up Blood
□ Sleep Apnea			
Gastrointestinal:			
□ Abdominal Pain	□ Nausea	□ Vomiting	□ Constipation
□ Change in Appetite	□ Black or Tarry Stools	□ Frequent Diarrhea	□ Vomitting Blood
□ Dyspepsia	□ GERD		
Genitourinary:			
□ Urinary Loss of	□ Difficulty Urinating	□ Increased Urinary Frequency	□ Hematuria
□ Incomplete			
Musculoskeletal:			
□ Muscle Aches	□ Muscle Weakness	□ Arthraigias / Joint Pain	□ Back Pain
□ Extremity Swelling	□ Neck Pain	□ Difficulty Walking	□ Cramps
□ Osteoporosis	□ Fractures		
Integumentary:			
□ Abnormal Mole	□ Jaundice	□ Rash	□ Itching
□ Dry Skin	□ Growths / Lesions	□ Laceration	□ Non-Healing Areas
□ Changes in Hair /	□ Psoriasis	□ Changes in Skin Color	□ Breast Lump
Neurologic:			
□ Loss of	□ Weakness	□ Numbness	□ Seizures
□ Dizziness	□ Migraines	□ Restless Legs	□ Frequent / Severe Headaches
□ Tremor	□ Gait Dysfunction	□ Paralysis	
Psychiatric:			
□ Depression	□ Sleep Disturbance	□ Restless Sleep	□ Alcohol Abuse
□ Anxiety	□ Hallucinations	□ Mood Swings	□ Memory Loss
□ Agitation	□ Dementia		
Endocrine:			
□ Fatigue	□ Increased Thirst	□ Hair Loss	□ Increased Hair Growth
□ Cold Intolerance			
Hematologic/Lymphatic:			
□ Swollen Glands	□ Easy Bruising	□ Excessive Bleeding	□ Anemia
□ Phlebitis (Vein Inflammation)	□ Jaundice	□ Rash	□ Itching
Allergy/Immunologic:			
□ Runny Nose	□ Sinus Pressure	□ Itching	□ Hives
□ Frequent Sneezing			

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Patient Registration

Last Name_____ First Name _____ Middle Initial_____

Date of Birth_____SSN_____

Address_____Apt/Unit_____

City_____State_____Zip_____ Driver's License No_____ State Issued_____

Gender: □ Male □ Female

Primary Phone_____ □ Cell □ Home □ Work Is this your preferred phone ? □ Y □ N

Secondary Phone_____ □ Cell □ Home □ Work Is this your preferred phone ? □ Y □ N

Email address_____(by providing your email you consent to use our patient portal)

Relationship Status: S M W D Other Do you need an interpreter? Y / N

(Emergency Contact Information)

Name_____Relationship_____Phone_____

Guarantor (if not patient) Last Name _____First Name_____ Middle Initial_____

Birthdate_____ SSN_____

Address_____ Apt/Unit_____

City_____State_____ Zip_____

(Primary Insurance)

Insurance Name_____ID#_____Group#_____

Policy Holder **(if not patient)**
Name_____DOB_____SSN_____

(Secondary Insurance)

Insurance Name_____ID#_____Group#_____

Policy Holder **(if not patient)**
Name_____DOB_____SSN_____

I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original. I hereby authorize Arizona Diabetes & Endocrinology, PLC to apply for benefits on my behalf and I request that payment from my insurance company be made directly to Arizona Diabetes & Endocrinology, PLC for medical benefits otherwise payable to me. **I understand that I am financially responsible for charges not covered by my insurance.** I hereby certify that the information I have reported with regard to my insurance coverage is correct.

Patient Signature_____ Date_____

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HIPAA and Release of PHI

Last Name _____First Name_____Middle Initial_____ DOB:_____

☐ I Do ☐ I Do NOT give my permission for AZDNE to leave messages regarding my lab results, treatment, diagnosis, appointments, billing/payments, and any other pertinent information regarding my care at the following number(s):

Mobile Number_____Home Number_____

Do you consent to receive automated **email** messages from our office? Yes / No

Do you consent to receive automated **phone** messages from our office? Yes / No

Do you consent to receive automated **text** messages from our office? Yes / No

By signing below, I acknowledge that I have received the Notice of Privacy Practices of AZDNE which explains its legal duties and privacy practices with respect to my Protected Health Information (PHI). I understand that I may refuse to sign this acknowledgement. I authorize AZDNE to disclose my PHI as specified below to the individuals listed below.

Name_____Relationship_____Phone_____

Information to be released (circle): ALL / Treatment / Diagnosis / Appointment / Billing / Other _____

Name_____Relationship_____Phone_____

Information to be released (circle): ALL / Treatment / Diagnosis / Appointment / Billing / Other _____

Name_____Relationship_____Phone_____

Information to be released (circle): ALL / Treatment / Diagnosis / Appointment / Billing / Other _____

The above authorizations shall remain in effect until I provide Arizona Diabetes & Endocrinology, PLC with written revocation. I understand I cannot revoke this authorization retroactively for information already released. I understand when Arizona Diabetes & Endocrinology, PLC discloses PHI pursuant to this authorization, they can no longer guarantee confidentiality or prevent re-disclosure and the information may no longer be protected by federal privacy rules. I understand by signing this authorization I agree to allow Arizona Diabetes & Endocrinology, PLC and its staff to disclose the protected health information to the above stated person(s) and/or entity.

Patient or legally authorized representative Signature_____ Date_____

Printed name if signed on behalf of the patient _____ Relationship _____

FOR OFFICE USE ONLY

I, _____(Employee Name), made a good faith effort to obtain written acknowledgement of the receipt of the Notice of Privacy Practices of AZDNE for the above-named patient. I was unable to obtain written acknowledgement due to the following reason:

☐ Individual refused to sign ☐ Communication barrier ☐ An emergency situation ☐ Other _____

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Office and Financial Policies

OFFICE & PHONE HOURS: Our office is open Monday through Thursday from 8:00AM-5:00PM and Friday from 8:00AM-12:00PM. Our phone lines close for lunch from 12:00-1:00. Phone lines are not open past noon on Friday.

LAB HOURS: We will offer in-office phlebotomy services Monday through Thursday from 8:00AM-11:30AM and 1:00PM-4:30PM as well as Friday from 8:00AM-11:30AM. We do not draw outside orders unless they are presented in conjunction with an order from one of our providers. **Lab Services are by appointment Only.**

APPOINTMENT ARRIVAL and CONFIRMATION/CANCELLATION: **We require ALL new patients to arrive 30 minutes prior to their scheduled time.** This allows our clinical staff to perform intake and minimize the wait time for all patients. If you arrive more than 10 minutes late your appointment will be rescheduled at the provider's discretion. **IF YOU NO SHOW OR CANCEL YOUR APPOINTMENT WITHIN 24 HOURS, YOU WILL BE CHARGED A $50 FEE. _____ (Initials)**

If the provider has ordered bloodwork, please have this done 1-2 weeks prior to your appointment. **If the results are not in our office 72 hours prior to your visit we will cancel your appointment. _____ (Initials)**

INSURANCE: We only bill for services rendered by Arizona Diabetes & Endocrinology. If you would like us to bill your medical insurance, you must present a current insurance card to our receptionist each time you visit our office. If we do not have a valid card on file or are unable to verify your eligibility, payment of our cash fee will be expected at the time of service. If your insurance denies payment you are financially responsible for the balance due. Questions regarding claim payment should be directed to your insurance company directly. **_____ (Initials)**

REFERRALS: If your insurance company requires a referral to see a specialist, the referral must be on file in our office in order for you to be seen by the provider**. It is your responsibility to ensure we have a valid referral** including a referral number (if required by insurance) as well as a valid number of visits and current date range authorized by your primary care physician. You will be asked to reschedule your appointment if we do not have a valid referral at the time of check-in. . **_____ (Initials)**

COPAYS: If your insurance plan requires a copay, it is due at the time of your visit. **_____ (Initials)**

OUTSTANDING ACCOUNT BALANCE: Your account balance must be paid in full prior to seeing the provider. If you are unable to pay your balance you may ask to setup a payment plan. If you default on the payment plan, your account will be sent to our collection agency and we will not be able to schedule future appointments. **_____ (Initials)**

COLLECTION ACCOUNTS and RETURN CHECK FEE: Accounts that are 90 days past due will be sent to an external collection agency and the patient will be discharged from our practice for non-payment. A fee of $30 will be assessed for any returned check. **_____ (Initials)**

PRESCRIPTION REFILLS: Prescription refill requests should be directed to your pharmacy. Requests will be processed within 48-72 hours. It is the patient's responsibility to plan ahead for refills as we do not guarantee a same-day response. **Refills will not be given to patients who do not attend regularly scheduled appointments. _____ (Initials)**

LAB ORDERS: Lab orders are sent electronically to the preferred lab in accordance with your insurance. Please contact the draw station directly in order to verify whether or not your order is on file. We do not send lab orders through the mail.

ON-CALL SERVICES: A provider will be on-call after business hours for emergencies only. Prescription refills WILL NOT be addressed by the on-call provider. Please plan ahead to ensure you are requesting refills before running out of your medication(s). **_____ (Initials)**

I have read the above policies and I agree to abide by them. I understand policies may change without notice and it is my responsibility to seek updated information from the practice website or material posted in the office.

Name_____Signature_____Date_____

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Authorization for Release of Medical Information

Patient Name (Please Print):_____Date of Birth:_____

□ Obtain Information From **OR** □ Release Information To
Mark One Selection: Physician Facility Self Other

Name: _____Phone: _____Fax: _____

Address: _____

Information to be Released:
□ Complete Records □ Billing Information
□ Progress Notes □ Biopsy/Pathology Report
□ Lab/X-Ray Reports □ Surgical Report
□ Whole Body Scan □ Other: _____

Information to be Restricted:
The patient restricts the release of the following:
□ Behavior & Mental Health Records
□ Communicable Diseases (including HIV/AIDS
□ Alcohol & Drug Abuse Treatment
□ Genetics □ Other

Form and Method of Release:
Records should be sent by □ Hard Copy/Paper □ Soft Copy/Electronic Format

□ Mail to address above □ Fax to number above □ Notify patient to pick-up when ready
(Requests containing more than 30 pages must be picked up or mailed in electronic format)

Service Dates:
□ All Dates **OR** □ From_____ to_____
Purpose of Release:
□ Treatment/Continuity of Care □ Legal Purposes
□ Transfer of Medical Care □ Moving
□ Insurance Coverage □ Personal
□ Disability Determination □ Other: _____

This authorization will expire one (1) year from the date of signing, or as indicated here: _____and may be revoked at any time by providing written notice of revocation. I understand I cannot revoke this authorization retroactively for information already released. I understand when Arizona Diabetes & Endocrinology, PLC discloses PHI pursuant to this authorization, they can no longer guarantee confidentiality or prevent re-disclosure and the information may no longer be protected by federal privacy rules. I understand by signing this authorization I agree to allow Arizona Diabetes & Endocrinology, PLC and its staff to disclose the protected health information to the above stated person(s) and/or entity. I understand my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this form.

Signature: _____ Date Signed: _____

Printed Name of Person Signing (if not patient): _____