Lakeside Endocrine Associates, Inc. Tel:(386) 274-1414 FAX:(386) 274-2215
1667 N Clyde Morris Blvd. Suite 2, Daytona Beach, Fl. 32117 referralspecialist@lakesideendocrine.com

PATIENT REGISTRATION

Last Name	First Name	Middle Name	Suffix

Date of Birth	Gender	Social Security Number	Marital Status

Street Address	City	State	Zip Code

Home Phone	Cell Phone	Work Phone

Preferred Pharmacy	Pharmacy Phone Number	E-mail address

Contact Preference (Home, Cell, Work, Email, Mail)	Language Preference

Ethnicity:
- ○ not of Hispanic origin
- ○ **Yes, of Hispanic origin** (person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.)
- ○ **Decline to Answer**

Race:

☐Refused	☐Native Hawaiian	☐Guamanian
☐White	☐Filipino	☐Samoan
☐White Hispanic or Latino	☐Chinese	☐Tongan
☐Black or African American	☐Japanese	☐Other Pacific Islander
☐Black Hispanic or Latino	☐Korean	☐Vietnamese
☐American Indian or Alaska Native	☐Other Asian	☐Unknown

Occupation	Name of Employer

Spouse's Name	Spouse's Employer	Work Number

Person to Notify on Case of Emergency	Phone Number of Person to Notify

Primary Care Physician	Tel #

Referred by:

Do we have you permission to:

Leave a message on your answering machine at home? Y○ N○
Leave a message at your place of employment? Y○ N○
Discuss your medical condition with any member of your household? Y○ N○

If yes, whom: _____ Relationship_____

Patient Signature _____ Date_____

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INSURANCE

NAME_____ AGE_____ DOB_____

Primary Insurance Carrier and Insurance Numbers:
Name of Insured (Subscriber):
Insured Relationship to Patient:
Secondary Insurance Carrier and Insurance Numbers:
Secondary Name of Insured (Subscriber)
Secondary Insured Relationship to Patient

PAYMENT IS EXPECTED AT THE TIME OF SERVICE, FOR "YOUR PART" OF THE CHARGES. We accept VISA and MasterCard for your convenience. Your signature below indicates that you understand and accept this policy.

Payment of Benefits

I request the direct payment of authorized medical benefits be made to *Lakeside Endocrine Associates* for any services I received by the physicians or laboratory of *Lakeside Endocrine Associates.* I authorize any holder of medical information about me to release this information as necessary to process my claims or meet legal requirements. I permit a copy of this authorization to be used in place of the original. This assignment will remain in effect until revoked, in writing. I understand that because these services were performed for me or my legal dependent, I am financially responsible for all charges incurred whether or not paid by the insurance carrier.

Beneficiary's Signature_____ Date_____

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New Patient Medical History

NAME_____ AGE_____ DOB_____

I. Reason for Consultation: (What brings you here today)

_____
_____
_____
_____

II. Past medical problems or diseases in past for which you have been diagnosed and/or treated:

1. **Cancer or tumors** ☐
2. **High Blood Pressure** ☐
3. **High Cholesterol** ☐
4. **High Triglycerides** ☐
5. **Diabetes** ☐
6. **Thyroid Problems** ☐
7. **Kidney Problems** ☐
8. **Heart Attacks** ☐
9. **Chest Pains** ☐
10. **Angina** ☐
11. **Bronchial asthma** ☐
12. **Respiratory problems** ☐
13. **Ulcers of stomach/duodenum** ☐
14. **Liver Problems** ☐
15. **Intestinal Problems** ☐
16. **Anemia** ☐
17. **Arthritis** ☐
18. **Other Conditions/Disease including psychiatric problems**
    _____
19. **Have you been diagnosed with lupus, rheumatoid arthritis, multiple sclerosis, Crohn's disease or any other autoimmune disease? Please describe (be brief)** _____
    _____
    _____

III. Surgical Operations/Fractures and traumas:
Tonsils ☐ **Appendix** ☐ **Gallbladder** ☐ **Thyroid** ☐ **Heart Surgery** ☐
Hernia ☐ **Other**_____

1. **Bone Fractures:**_____
2. **Head traumas:**_____
3. **Other:** _____

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Family Medical History:

NAME_____AGE_____ DOB_____

1. **Adopted___ Unknown___**
2. **Mother: problems or disease: _____**
3. **Maternal side: problems or disease:_____**
4. **Father: problems or disease:_____**
5. **Paternal side: problems or disease: _____**
6. **Children (your own): problems or disease_____**
7. **Brothers: problems or disease:_____**
8. **Sisters: problems or disease:_____**
9. **History of autoimmune disease such as lupus, rheumatoid arthritis, multiple sclerosis, Cohn's disease or any other? Please describe. Be Brief.**

_____

_____

Medicines: Please list name, strength and how often medicine is taken:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Allergies: Please List

1. **Food** _____
2. **Pollen**_____
3. **Drugs**_____
4. **Other**_____

Please List any other specialist you see and the office phone number.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Do you smoke? Y○ N○ If yes, how much, _____packs per day

Do you drink alcohol? Y○ N○ If yes, how many _____drinks per day/week/Month

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MEDICAL QUESTIONS:

NAME_____ **AGE**_____ **DOB**_____

1. Do you sleep well?	**Y ○**	**N ○**
2. Do you eat healthy?	**Y ○**	**N ○**
3. Do you exercise regularly?	**Y ○**	**N ○**
4. Are you under stress?	**Y ○**	**N ○**
5. Are you happy?	**Y ○**	**N ○**
6. Are you in pain?	**Y ○**	**N ○**
Where_____		
7. Do you have loss of appetite?	**Y ○**	**N ○**
8. Are you gaining weight?	**Y ○**	**N ○**
9. Are you losing weight?	**Y ○**	**N ○**
10. Do you feel depressed most of the day?	**Y ○**	**N ○**
11. Diminished interest/pleasure in activities	**Y ○**	**N ○**
12. Increase in appetite?	**Y ○**	**N ○**
13. Decrease in appetite?	**Y ○**	**N ○**
14. Insomnia?	**Y ○**	**N ○**
15. Hypersomnia (significant amounts of sleep)	**Y ○**	**N ○**
16. Feeling Physically/emotionally agitated or anxious?	**Y ○**	**N ○**
17. Feeling physically "slowed down"?	**Y ○**	**N ○**
18. Fatigue or loss of energy?	**Y ○**	**N ○**
19. Feeling of worthlessness?	**Y ○**	**N ○**
20. Excessive or inappropriate guilt?	**Y ○**	**N ○**
21. Diminished ability to concentrate or make decisions?	**Y ○**	**N ○**
22. Recurrent thoughts of death?	**Y ○**	**N ○**
23. Loss if interest in sex?	**Y ○**	**N ○**
24. Suicidal thoughts	**Y ○**	**N ○**
25. Rarely smiles or laughs	**Y ○**	**N ○**
26. Do symptoms occur nearly every day for a 2 week period?	**Y ○**	**N ○**
27. Does your health limit you in carrying out your regular Daily responsibilities (showering, cleaning yourself, Brushing your teeth, getting dressed, eating)	**Y ○**	**N ○**
28. Does your health limit or interfere with your usual social Activities (lifting weights, driving, exercising, climbing steps)	**Y ○**	**N ○**
29. Does your heath limit or interfere with your usual social Activities with your family and friends (parties)	**Y ○**	**N ○**
30. Does your health limit or interfere with your intellectual	**Y ○**	**N ○**
Activities with your family and friends (parties)	**Y ○**	**N ○**
31. Does your health limit or interfere with you intellectual Activities (teaching, memorizing, analyzing, concentration, Or participating in meetings)	**Y ○**	**N ○**