PATIENT INFORMATION

ENDOCRINE CONSULTANTS OF MORRIS COUNTY

10 JAMES ST. SUITE 140

FLORHAM PARK, NJ 07932

PATIENT NAME _____

DOB:_____ SEX:_____ MARITAL STATUS:_____ SOCIAL SECURITY#_____

ADDRESS:_____ CITY:_____ STATE:_____ ZIP:_____

HOME PHONE:_____ CELLPHONE:_____

EMPLOYER:_____ OCCUPATION:_____

EMPLOYER ADDRESS:_____ CITY:_____ STATE:_____ ZIP:_____

WORK PHONE:_____ EMAIL ADDRESS:_____

EMERGENCY CONTACT INFORMATION

NAME:_____ PHONE:_____ RELATIONSHIP:_____

NAME:_____ PHONE:_____ RELATIONSHIP:_____

MAY WE LEAVE CONFIDENTIAL MESSAGES WITH A FAMILY MEMBER? YES NO

PLEASE INDICATE NAMES:_____

MAY WE LEAVE CONFIDENTIAL MESSAGES ON YOUR ANSWERING MACHINE? YES NO

GUARANTOR OR GUARDIAN INFORMATION

NAME: _____ DOB:_____

ADDRESS: _____ CITY:_____ STATE:_____ZIP:_____

HOME PHONE: _____ WORK PHONE: _____

EMPLOYER: _____

EMPLOYER ADDRESS: _____ CITY:_____ STATE:_____ ZIP:_____

AUTHORIZATION FOR INSURANCE PAYMENT/CONSENT FOR TREATMENT

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO ENDOCRINE CONSULTANTS OF MORRIS COUNTY (ECMC). I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE TO MY PHYSICIAN FOR ALL FEES INCURRED. I HEREBY AUTHORIZE ECMC TO RELEASE MY MEDICAL INFORMATION TO MY THIRD PARTY TO OBTAIN PAYMENT. I UNDERSTAND THAT PAYMENT IS EXPECTED AT THE TIME OF SERVICES ARE RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE PRIOR. I HEREBY CONSENT TO TREATMENT FOR ANY CONDITIONS OR INJURIES. I HAVE COMPLETED THIS FULLY AND TRUTHFULLY AND CERTIFY THAT I AM THE PATIENT OR GUARDIAN OF PATIENT AUTHORIZED TO FURNISH THE INFORMATION REQUESTED.

SIGNATURE_____

ENDOCRINE CONSULTANTS OF MORRIS COUNTY, LLC

NEW PATIENT MEDICAL HISTORY

PATIENT NAME (Last, First) _____ Date: ___/___/____ Age:____

PRESENT PROBLEM

Reason for Visit: _____

When did you first develop this problem (date or number of weeks/months you have had the problem) _____

Is this the first time that you have had this problem? Yes No

Have you been treated for this problem before? Yes No

Brief summary of treatment up to this point. Please give dates of any tests, surgeries or hospital admissions.

_____

Name and location of any physician who has treated you for this problem_____

ENDOCRINE HISTORY

Please indicate any endocrine/hormone problems you have had in the past: ☐ No Previous endocrine problems

☐ Pituitary Disorders ☐ Osteoporosis ☐ Hyperthyroid ☐ Obesity

☐ Diabetes ☐ Osteopenia ☐ Polycystic Ovarian Syndrome

☐ Adrenal Disorders ☐ Hypothyroid ☐ Thyroid Nodule(s) ☐ Other

Please specify:_____

PAST MEDICAL HISTORY

Please indicate any medical problems you have or have had in the past: ☐ No medical problems

☐ Asthma ☐ Bleeding Disorder ☐ Cancer (Type _____) ☐ Stroke

☐ Heart Failure ☐ Fibromyalgia ☐ High Blood Pressure ☐ Depression

☐ Abnormal Heart Beat ☐ Lyme's Disease ☐ Kidney Disease ☐ High Cholesterol

☐ Heart Attack ☐ Rheumatoid Arthritis ☐ Hepatitis/ Liver Disease ☐ Diabetes

☐ Heart Disease ☐ Blood Clot/ DVT ☐ Peptic Ulcers/ GI Bleed ☐ Gout

☐ Osteoporosis ☐ Osteoarthritis ☐ Other (please specify)_____

ENDOCRINE CONSULTANTS OF MORRIS

PAST SURGICAL HISTORY

Please indicate any surgeries you have had in the past: ☐ No medical problems

For any surgeries, please list an approximate date of when the surgery was performed.

☐ Appendectomy	☐ Tonsillectomy	☐ Hernia Repair	☐ C-Section
☐ Thyroid Surgery	☐ Orthopedic Surgery	☐ Neurosurgery	☐ Back/Neck Surgery
☐ Cardiac Bypass	☐ Cardiac Catheterization	☐ Gastric Bypass	☐ Lung Surgery

---

FAMILY HISTORY

Does anyone in your immediate family have a history of any of the following? ☐ No significant family history

☐ Asthma	☐ Osteoporosis	☐ Cancer (Type) _____	☐ Kidney Disease
☐ High Blood Pressure	☐ Heart Attack	☐ High Cholesterol	☐ Heart Disease
☐ Diabetes	☐ Thyroid Disorders	☐ Stroke	☐ Other (specify)____

ALLERGIES

Are you allergic to any medications? ☐ None If yes, please list:_____

MEDICATIONS

Please list ALL medications and dosages you are currently taking (including over-the-counter medicines like Tylenol, Advil, etc.) If you have a list of your medicines, you may give a copy to the receptionist.

☐ No Medications

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

PHARMACY INFORMATION

What pharmacy do you use? _____Where located?_____ Phone#_____

ENDOCRINE CONSULTANTS OF MORRIS COUNTY, LLC

SOCIAL HISTORY

What is your occupation? _____ Does your job involve ☐ desk work ☐ manual labor ☐ standing

Do you or did you ever use any of the following?

Cigarettes Yes No If yes, # of packs/day _____ For how many years _____ If quit, how long ago_____

Other tobacco forms Yes No If yes, please specify type and quantity _____

Alcohol Yes No If yes, # of drinks per day or week _____

Other Drugs Yes No If yes, please specify _____

REVIEW OF SYSTEMS

Do you currently have a problem in any of the following areas:

☐ Nervous System	☐ Eyes	☐ Ears, Nose or Throat	☐ Heart or Blood Vessels
☐ Lungs	☐ Stomach/Intestines	☐ Kidney, bladder, genitals	☐ Muscles, bones, joints
☐ Skin or breasts	☐ Psychiatric	☐ Glands or Hormones	☐ Blood

Please provide details on any item(s) checked: _____

AUTHORIZATION and PRIVACY POLICY

I hereby give authorization to *Endocrine Consultants of Morris County, LLC* and its staff for **treatment and for the release of medical information** necessary to process claims, payments and appeals. I agree that a photocopy or fax of this form may be used in place of the original.

I acknowledge that I have received a copy of the ***Notice of Privacy Practice*** *of Endocrine Consultants of Morris County.*

PATIENT SIGNATURE _____ Date: _____

Please Print Name: _____

ECMC MISSED APPOINTMENT POLICY

Please cancel your appointment at least 24 hours in advance if you want to cancel or make a change to your appointment. This will allow us to fill your spot with a patient who is waiting to be seen by the doctor. **ECMC** will charge a missed appointment fee if a patient fails to cancel an appointment at least 24 hours in advance according to the following fee schedule:

1. Established patient follow up visit: **$50**
2. New patient initial consultation: **$100**
3. Ultrasound with or without Biopsy: **$150**
4. A second missed appointment will result in an additional **$50** charge of above.
5. Patient who misses 3 appointments without the required 24-hour notification may be asked to transfer their records to another doctor.

This policy will hopefully prevent last-minute cancellations.

I have received, understand and accept the terms of this policy.

Signed _____ **Date** _____