Today's Date _____

Patient Name _____ Gender M F
Last First Middle

Date of Birth (MM/DD/YYYY) ___/___/___ Age ___ Social Security Number ___-___-____

Marital Status _____ Email_____

Address _____ Home Phone _____

_____ Cell Phone _____

Employer _____ Pharmacy Name _____

Work Number _____ Pharmacy Number _____

Emergency Contact

Name _____ Relationship _____ Phone Number _____

Family Doctor _____ Office Number _____

Referring Doctor _____ Office Number _____

Insurance Information (Insurance Company, Policy Number, Contact Number)

Insurance Carrier_____ Contact #_____

Policy # _____ Policy Holder _____

Group # _____ Relationship _____

Subscriber Information (Policy Holder)

SS#____--____--_____ DOB _____

Employer _____ Employer Address _____

Additional, or Secondary Insurance Company

Insurance Carrier _____ Contact # _____

Policy # _____ Policy Holder _____

Group # _____ Relationship _____

Subscriber Information (Policy Holder)SS#____--____--_____ DOB _____

Employer _____ EmployerAddress_____

7921 **Jones Branch Drive Suite #320 McLean, Virginia 22102**
Phone: 703-448-6010 Fax: 703-506-6726 info@endocrineassociates.com

The above information is true to the best of my knowledge. I hereby authorize Harvey A. Rubenstein, MD, PC, Frank R. Crantz, MD and
S. Mark Tanen, MD, LLC to apply for benefits on my behalf (or my child's) for services rendered. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the doctor. I authorize release of any information concerning my health care, advice and treatment provided for the purposes of evaluation and administering claims for insurance benefits. In compliance with state regulation records are retained for 6 (six) years after the first date of service.

Patient/Guardian Signature _____ Date _____

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Name:_____

Why are you seeing the doctor today?:

_____

_____

_____

Please list all your medications, with dosage if known (include over-the-counter medications):

_____

_____

_____

_____

_____

Please list any drug allergies or adverse reactions to medications:

_____

_____

_____

Personal History:

What is your current occupation?:_____

Place of birth:_____

Do you smoke?_____ If yes, how much?_____If quit, when?_____

Do you drink alcohol?_____ If yes, how much?_____

Number of pregnancies?_____Number of children?_____

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Past Medical History:

Please list all operations, with year of surgery:

_____

_____

_____

_____

_____

Please list any other hospitalizations or ongoing medical problems:

_____

_____

_____

_____

_____

Family Medical History:

Please list any family members with the following:

Cancer_____

Diabetes_____

Heart Disease_____

Osteoporosis_____

Thyroid Disease_____

Hypertension_____

Other (Adrenal, Parathyroid, Pituitary, etc.)_____

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REVIEW OF SYSTEMS. PLEASE COMPLETE IF ANY ARE POSITIVE:

RECENT SKIN PROBLEMS? _____
RECENT CHANGE IN YOUR HAIR? _____
DO YOU PERSPIRE EXCESSIVELY? _____
CHANGE IN SKIN COLOR? _____

RECENT CHANGE IN VISION? _____
DO YOU GET HEADACHES MORE OFTEN THAN OTHERS?_____
ANY OTHER DIFFICULTIES WITH YOUR EYES? _____
PROBLEMS WITH YOUR EARS OR HEARING? _____
PROBLEMS WITH YOUR TEETH OR GUMS? _____

FREQUENT OR SEVERE SORE THROAT? _____
ARE YOU SUBJECT TO HOARSENESS? _____
DO YOU HAVE DIFFICULTY SWALLOWING? _____

DOES HOT OR COLD WEATHER BOTHER YOU MORE THAN OTHERS? _____
HAVE YOU EVER BEEN TOLD OF A THYROID PROBLEM? _____
HAVE YOU EVER HAD ANY THERAPEUTIC RADIATION TO YOUR HEAD OR NECK
(NOT INCLUDING ROUTINE DIAGNOSTIC X-RAY STUDIES)? _____

DO YOU HAVE A CHRONIC COUGH? _____
ANY BREATHING OR LUNG PROBLEMS? _____
ANY HISTORY OF HEART DISEASE OR HIGH BLOOD PRESSURE? _____
DO YOU HAVE SIGNIFICANT SWELLING OF YOUR ANKLES? _____
DO YOU NOTICE AN IRREGULAR HEART BEAT OR PALPITATIONS?_____

ANY SIGNIFICANT CHANGE IN APPETITE? _____
DO YOU HAVE FREQUENT INDIGESTION? _____
ANY CHANGE IN PATTERN OF BOWEL MOVEMENTS? _____
ANY RECENT WEIGHT CHANGES? _____

HOW OFTEN DOYOU AWAKEN FROM SLEEP TO URINATE? _____
HAVE YOU EVER HAD KIDNEY STONES? _____
ANY HISTORY OF KIDNEY PROBLEMS? _____

ANY JOINT OR MUSCLE PROBLEMS? _____
ANY NEUROLGIC PROBLEMS? _____
ANY TINGLING OR NUMBNESS? _____

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PROBLEMS WITH HEADACHES? _____
EPISODES OF LIGHTHEADEDNESS OR DIZZINESS? _____

**********WOMEN**********

ARE YOU PERIODS FREQUENTLY IRREGULAR? _____
ANY HOT FLASHES OR OTHER MENOPAUSAL SYMPTOMS? _____
ANY DISCHARGE FROM THE BREASTS? _____

**********MEN**********

ANY DIFFICULTY GETTING OR MAINTAINING AN ERECTION? _____
ANY HISTORY OF A PROSTATE DISORDER? _____
ANY TESTICULAR PAIN OR SWELLING? _____

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HARVEY A. RUBENSTEIN, MD, PC
FRANK R. CRANTZ MD
S. MARK TANEN, MD, LLC

DIPLOMATES OF THE AMERICAN BOARD OF INTERNAL MEDICINE
DIPLOMATES OF THE SUBSPECIALTY BOARD OF ENDOCRINOLOGY AND METABOLISM

Consent Agreement

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that health care providers provide a Privacy Notice and, optionally, may require a signed Authorization as it relates to the use and disclosure of individually identifiable health information (IIHI). This allows IIHI to be used or disclosed for treatment, payment and other health care operations (TPO) purposes only, unless the patient specifically denies authorization.

Though not necessary to have your consent to allow us to use or disclose your IIHI to others who will treat you or support in providing you quality health care services, it is important to have you consent to use or disclose your IIHI to health care plans to insure accurate and timely payments for the services rendered. The law requires that we inform you of our policy regarding the protection of your IIHI and to provide you with our Privacy Notice. We may already have a consent agreement from you, but under the new Privacy Standard, we are required to provide our Privacy Notice that specifically addresses the use or disclosure of your IIHI. Please refer to our Privacy Notice for a full explanation of how this office will protect your individually identifiable health information (IIHI).

As of September 23, 2013 under the omnibus rulemaking HHS implemented a number of provisions of the HITECH Act to strengthen the privacy and security protections for health information established under HIPAA.

Thank you for your continued confidence in our practice and for supporting our new requirements.

The following is a statement that allows us the necessary latitude to work within the new requirements.

I have been given a copy of Frank R Crantz, MD's, Harvey A Rubenstein MD PC's and S Mark Tanen MD LLS's Notice of Privacy Practices, version effective September 23, 2013. I consent to the uses and disclosures of my health information as outlined in the notice.

.

Printed Patient Name or Representative: _____

Signature of Patient or Representative:_____

Date: _____

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