Spring ENDOCRINOLOGY

7055 N. Chestnut Ave #103, Fresno, CA 93720 **559.216.0407**

PATIENT INFORMATION

Name _____ SS#_____
Birthdate _____ Marital Status _____ Sex _____ Phone _____
Address _____ City_____ State _____ Zip_____
Employment ❑ Full-time ❑ Part-time ❑ Unemployed ❑ Self Employed ❑ Retired (date) _____
Employer _____ Occupation _____
Address _____ City _____ State _____ Zip _____
Work Phone _____ Extension _____

GUARANTOR (NAME OF INSURED)

* If same as patient, please skip to next section

Relationship to patient_____ Name_____
LAST FIRST MIDDLE
Birthdate _____ Home Phone _____ SS# _____
Address _____ City _____ State _____ Zip_____
Employer _____ Occupation _____
Employer Address_____ Work Phone _____

PHYSICIAN / EMERGENCY CONTACT

Referring Physician _____
Primary Care / Family Physician _____
Emergency Contact Name _____ Relationship to Patient _____
Address _____ City _____ State _____ Zip_____
Home Phone _____ Work Phone _____ Employer _____

INSURANCE INFORMATION

Insurance Company Name _____ Policy Holder Name _____
Policy Holder Date of Birth_____ Policy Holder Social Security # _____
Patient Relationship to Policy Holder _____

I certify that I have read and agree to Spring Endocrinology's payment Policy. I am eligible for the insurance indicated on this form and I understand that payment is my responsibility regardless of insurance coverage. I authorize Spring Endocrinology to release any medical information to my insurance carrier or third party payer to facilitate processing my insurance claims. I understand that failure to pay outstanding balances within 90 days of notification of the amount due will result in submission to an outside collection agency. A $40.00 returned check fee will be charged for checks returned due to insufficient funds. MEDICARE BENFEFICIARIES: I request that payment of authorized Medicare benefits be made to Spring Endocrinology. I authorize Spring Endocrinology to release to CMS and its agents any information needed to determine these benefits or the benefits payable for related services.

Signature of Responsible Party _____ Date _____

Spring ENDOCRINOLOGY

NAME: **DATE:**

PAST MEDICAL HISTORY

Please check YES or NO if you presently have or have ever been diagnosed with any of the following:

	YES	NO			YES	NO
High blood pressure				Pregnant (currently)		
Any heart problems				Asthma		
Do you have a pacemaker				Bronchitis		
Stroke				Emphysema		
Cancer				Kidney disease		
Lung disease				Liver disease		
Seizures				Latex allergy		
Diabetes				Do you smoke		
Low blood sugar				Feel faint or have spells of severe dizziness		

Adverse and Allergic Drug Reactions: _____

Are you receiving any treatment for any other medical condition: _____

_____

PATIENT SUMMARY LIST

Family Medical History including Diabetes: _____

_____

Significant Operative and Invasive Procedures: _____

_____

Significant Medical Diagnoses or Conditions:

_____

Medications (including Prescriptions, Herbals and Over-the-Counters Drugs):

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

NAME: **DATE:**

SHARING YOUR INFORMATION

There may be occasions when our office needs to contact you concerning your appointment, health information, billing problems or any other situation relating to your visit at our office. Please choose yes or no to the following statements.

I give permission to be contacted by phone and for messages to be left at this number.	❑ Yes Cell _____ Home _____ Work _____ ❑ No
I give permission to mail letters, documents and postcards to my home address.	❑ Yes ❑ No

CONSENT FOR TREATMENT, AUTHORIZATION, ASSIGNMENT OF BENEFITS AND REFERRAL RELEASE

Consent for Treatment: I consent and Authorize Spring Endocrinology providers or designated qualified assistants to provide Medical Treatment and to use and release my protected health information for treatment, payment, and healthcare operations as allowed by HIPAA and as described in the Spring Endocrinology Notice of Privacy Practices, a copy of which has been made available to me.

Authorization for Release of Medical Information: I understand that my medical information, including complete medical records, test results, and billing information, may be released to my insurance company and to other medical professionals and/or medical care institutions for treatment and payment purposes.

Assignment of Insurance Benefits: I hereby assign all of my rights and allow payment to be made directly to Spring Endocrinology for all medical or surgical benefits otherwise payable to me under terms of my insurance.

Payment Guarantee: I understand and agree that I am responsible for paying all co-payments, co-insurance, deductibles and non-covered services rendered by Spring Endocrinology, including charges for services not covered by my insurance. I consent and authorize Spring Endocrinology and third-party agents of Spring Endocrinology to contact me by telephone at any number associated with me and to use a pre-recorded and /or automated dialing service in connection with any communication made to me or related to my account.

To the best of my knowledge the information I have given on this form is accurate and true. I know it is my or my legal guardian's responsibility to keep Spring Endocrinology informed of changes to my contact information and insurance information. A failure to keep Spring Endocrinology informed may interfere with the ability to contact me concerning my healthcare.

WITNESS: _____ **SIGNED:** _____
(Patient or Representative)

DATE: _____ **BY:** _____

TIME: _____ **AM / PM** **RELATIONSHIP TO PATIENT:** _____