ROSEVILLE ENDOCRINOLOGY

508 Gibson Drive, #270, Roseville, CA 95678

Phone: 916-786-6727 | Fax: 916-786-6748

NEW PATIENT FORM

PATIENT INFORMATION

First Name: _____ Last Name: _____

○ Male ○ Female Age: _____ Date of Birth: _____ / _____ / _____
Month *Day* *Year*

Home Phone: _____ Cell Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Social Security #: _____

Employer: _____

Work Phone: _____ Email Address: _____

INSURANCE INFORMATION

Primary Insurance: _____

Responsible Party: _____

Address *(if different from patient information)*: _____

City: _____ State: _____ Zip: _____

Date of Birth *(if different from patient information)*: _____ / _____ / _____
Month *Day* *Year*

Policy Number #: _____ Group #: _____

Insurance Phone #: _____

Secondary Insurance: _____

Responsible Party: _____

Group #: _____ Policy Number #: _____

Insurance Phone #: _____

PHARMACY INFORMATION

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone #: _____ Fax #: _____

MAIL ORDER PHARMACY INFORMATION

❑ *Information is same as above*

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone #: _____ Fax #: _____

MARITAL STATUS

❑ Married ❑ Single ❑ Divorced ❑ Separated ❑ Widowed

PREFERRED POINT OF CONTACT

❑ Home phone ❑ Work phone ❑ Cell phone ❑ Email

❑ Morning *(9am-Noon)* ❑ Afternoon *(Noon-4pm)* ❑ Evening *(4pm-8pm)*

PREFERRED LANGUAGE *(if other than English)*

_____

RACE

❑ American Indian/Alaska Native ❑ Asian ❑ Native Hawaiian ❑ Hispanic

❑ White/Caucasian ❑ Black/African American ❑ Other Pacific Islander ❑ Other

PAST MEDICAL HISTORY

*(Check **all** for which you are **currently** being treated or have been in the **past**)*

Type 1 Diabetes	❑ YES	❑ NO	Stroke	❑ YES	❑ NO
Type 2 Diabetes	❑ YES	❑ NO	Osteoporosis	❑ YES	❑ NO
Gestational Diabetes	❑ YES	❑ NO	Depression	❑ YES	❑ NO
High Blood Pressure	❑ YES	❑ NO	Sleep Apnea	❑ YES	❑ NO
High Cholesterol	❑ YES	❑ NO	Sexual Problems	❑ YES	❑ NO
Hypothyroidism	❑ YES	❑ NO	Kidney Disease	❑ YES	❑ NO
Hyperthyroidism	❑ YES	❑ NO	Foot Ulcer	❑ YES	❑ NO
Goiter	❑ YES	❑ NO	Cancer	❑ YES	❑ NO

PAST MEDICAL HISTORY CONTINUED

*(Check **all** for which you are **currently** being treated or have been in the **past**)*

Thyroid Cancer	❑ YES	❑ NO	Adrenal Disorder	❑ YES	❑ NO
Congestive Heart Failure	❑ YES	❑ NO	Eye Surgery	❑ YES	❑ NO
Heart Attack	❑ YES	❑ NO	Abnormal Hair Growth	❑ YES	❑ NO

Others: _____

_____

_____

_____

CURRENT MEDICATIONS

*(Please list **all** you are **currently** taking, including herbal supplements and vitamins)*

MEDICATION	DOSAGE

ALLERGIES

*(Please list **all** medications you have had allergic reactions to or cannot tolerate)*

MEDICATION	REACTION

SURGERIES / HOSPITALIZATION

*(Please list **all** surgeries you have had in the past)*

SURGERY / HOSPITALIZATION	DATE

FAMILY MEDICAL HISTORY

MOTHER	
FATHER	
BROTHER	
SISTER	
AUNT	
UNCLE	

SOCIAL HISTORY

Do You Smoke? ❑ YES ❑ NO How Much? _____ How Many Years? _____

Do You Get at Least 30 Minutes of Exercise at Least 3 Times Per Week? ❑ YES ❑ NO

Are You Currently Involved in a Sexual Relationship? ❑ YES ❑ NO

REVIEW OF SYSTEMS

*(Please check **all** you have experienced in the past 6 months)*

GENERAL

Weight gain ❑ YES ❑ NO
Weight loss ❑ YES ❑ NO
Fatigue ❑ YES ❑ NO
Loss of appetite ❑ YES ❑ NO
Difficulty with sleep ❑ YES ❑ NO
Weakness ❑ YES ❑ NO
Fever ❑ YES ❑ NO
Chills ❑ YES ❑ NO
Headache ❑ YES ❑ NO
Hair loss ❑ YES ❑ NO

EYES

Bulging eyes ❑ YES ❑ NO
Loss of vision ❑ YES ❑ NO
Laser treatment ❑ YES ❑ NO
Double vision ❑ YES ❑ NO
Blurry vision ❑ YES ❑ NO
Glaucoma ❑ YES ❑ NO
Cataracts ❑ YES ❑ NO

Frequent urination at night ❑ YES ❑ NO
Increase in size of hands or feet ❑ YES ❑ NO

RESPIRATORY

Difficulty in breathing ❑ YES ❑ NO
Cough ❑ YES ❑ NO
Difficulty breathing ❑ YES ❑ NO
Hemoptysis ❑ YES ❑ NO
Wheezing ❑ YES ❑ NO

CARDIOVASCULAR AND CHEST

Chest pain ❑ YES ❑ NO
Palpitations ❑ YES ❑ NO

GI SYSTEM

Nausea / Vomiting ❑ YES ❑ NO
Heartburn ❑ YES ❑ NO
Stomach pain ❑ YES ❑ NO
Diarrhea ❑ YES ❑ NO
Constipation ❑ YES ❑ NO

REVIEW OF SYSTEMS CONTINUED

*(Please check **all** you have experienced in the past 6 months)*

ENT/THYROID

Hoarseness of voice	❑ YES	❑ NO
Swelling in the neck	❑ YES	❑ NO
Difficulty in swallowing	❑ YES	❑ NO

ENDOCRINE

Excessive thirst	❑ YES	❑ NO
Excessive urination	❑ YES	❑ NO
Breast discharge	❑ YES	❑ NO
Heat intolerance	❑ YES	❑ NO
Cold intolerance	❑ YES	❑ NO

BLOOD

Anemia	❑ YES	❑ NO
Bleeding tendency	❑ YES	❑ NO
Heavy periods	❑ YES	❑ NO
Easy bruising	❑ YES	❑ NO

NEUROLOGIC

Burning	❑ YES	❑ NO
Numbness	❑ YES	❑ NO
Tingling	❑ YES	❑ NO

CONSENT TO TREAT

I hereby authorize and consent to the performance of examinations, diagnostic procedures and treatments which my physician and I agree are necessary. I understand that no guarantee has been made as to the results of the care, treatment and or medications given to me. This consent shall remain in effect until I choose to revoke it in writing.

Patient Signature: _____ Date: _____

REFERRING PHYSICIAN

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone #: _____ Fax #: _____

PRIMARY CARE PHYSICIAN

❑ *Information is same as above*

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone #: _____ Fax #: _____

ASSIGNMENT OF BENEFITS

FOR MEDICARE PATIENTS:

"I request that payment of authorized Medicare benefits be made either to me or on my behalf to Manish R. Upadhyay, MD, Inc. for services furnished to me by that physician / supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agent's information needed to determine these benefits or the benefits payable to related services." I understand that my signature requests that payment be made and authorizes release of medical information necessary to pay the claim.

Medicare #: _____ Date: _____

Patient Signature: _____

Printed Name: _____

FOR ALL PATIENTS:

I authorize the release of any medical or other information necessary to process my insurance claim. I also request payment of government benefits either to myself or to Manish Upadhyay, MD, Inc who accepts assignment.

Patient Signature: _____ Date: _____

I authorize payment of medical benefits to Manish Upadhyay, MD, Inc for services provided.

Patient Signature: _____ Date: _____

FINANCIAL POLICY

Our practice is committed to providing you with the best possible medical care. Please review the following information regarding patient responsibility for the payment of services provided.

Before your appointment, please review your insurance information regarding its policies on referrals, co-payments and deductibles that may be required. Office appointments are to be paid for at the time services are provided. This includes co-payments, co-insurance, deductibles and any outstanding balances. If our practice participates with your insurance plan, we will bill your insurance company for services provided. If your insurance company requires a referral to our practice from your primary care provider, please ensure this referral is sent to our office so that your appointment will be paid for. Our office will be happy to assist you in obtaining this referral.

Please bring your insurance card with you and present your card for verification at each appointment. Please note that any questions or complaints regarding your insurance coverage should be directed to your insurance company. If your insurance company happens to deny or does not respond to a claim that our practice has submitted for services to you, you may be liable for the expenses. If our practice does not participate with your insurance company or you do not have medical insurance, you will be required to pay the full cost of the office visit and any procedures or tests performed.

Payment for services can be made by cash, check or credit card including Discover, Mastercard and Visa. **Patient or responsible party will be charged $35 for any returned check.**

NO SHOW / LATE CANCELLATION POLICY:

If you can't keep your appointment, please give us at least two business days notice. That way we can schedule another patient who has been on wait list to see the doctor. If you are a NO SHOW, i.e, do not show up for your scheduled appointment or cancel or reschedule your visit without two business days notice, the cancellation fee would be $50.

I have read and understood the terms and conditions in this financial policy and agree to abide by them.

Patient Name: _____

Patient Signature: _____ Date: _____

INFORMATION REGARDING CONFIDENTIALITY

I have received my HIPPA information.

Patient Signature: _____ Date: _____