

**PERSONAL HEALTH HISTORY INFORMATION**

All questions contained in this questionnaire are strictly confidential and will become part of your medical record

<b>Name:</b>	<b>DOB:</b>
<b>Referring Doctor:</b>	<b>PCP:</b>
<b>Reason for visit:</b>	

**Preferred Pharmacy:** (if No Pharmacy Used, Please List A Pharmacy Near Your Place of Residence)

Local Pharmacy Name:	Address or Cross Streets:	Phone/Fax:
Mail Order Pharmacy:	Phone:	Fax:

**Preferred Lab and Imaging:** (if Unknown, Please Contact your Insurance Plan for Contracted Lab and Imaging)

<b>Lab:</b> <input type="checkbox"/> Sonora Quest <input type="checkbox"/> LabCorp <input type="checkbox"/> Other (List Name):
<b>Imaging:</b> <input type="checkbox"/> SimonMed <input type="checkbox"/> SMIL <input type="checkbox"/> Banner Imaging <input type="checkbox"/> Other (List Name):

**Medications and Supplements:**  Check Here if No Current Medications or Supplements

Drug Name	Dose	How Many Times A day

**Allergies:** (Please List Reaction If Applicable)  Check Here if No Current Allergies


**Immunizations:**  Check Here if No Recent Vaccinations  Check Here for Vaccine Refusal

<b>Influenza Vaccine</b>	<b>Date Vaccinated:</b>
<b>Pneumonia Vaccine</b>	<b>Date Vaccinated:</b>
<b>Other: (COVID-19)</b>	<b>Date Vaccinated:</b>

**Arizona Diabetes & Endocrinology, PLC ~Shabeena Shaik, MD  
Jesse Lyon, PA-C ~Raquel Castaneda, FNP-BC, CDE ~Julie Linn, PA-C**

3489 S. Mercy Road, Suite 101, Gilbert, AZ 85297 Phone (480) 646-8433 Fax (480) 646-8434 www.azdne.com

**Past Medical Conditions:**  Check Here if No Past Medical Conditions

<input type="checkbox"/> Anxiety	<input type="checkbox"/> Coronary Artery	<input type="checkbox"/> Hyperlipidemia (Elevated	<input type="checkbox"/> Muscle, Joint, Bone
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Depression	<input type="checkbox"/> Hypertension (Elevated Blood Pressure)	<input type="checkbox"/> Obesity
<input type="checkbox"/> Asthma	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Hyperthyroidism	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Birth Defects/Inherited	<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> Hypothyroidism	<input type="checkbox"/> PCOS
<input type="checkbox"/> COPD	<input type="checkbox"/> Gout	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Pituitary Disorder
<input type="checkbox"/> Cancer Type:	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Stroke
<input type="checkbox"/> Thyroid Problem Type:		<input type="checkbox"/> Other:	

**Prior Surgeries:** (Please List Date/Year If Applicable)  Check Here if No Past Surgeries


**Recent Hospitalizations:** (Please List Reason, Date, Hospital Name and Location)  Check Here if No Recent Hospitalizations


**Diabetes Examination:**  Check Here if No Diabetes Examination Has Been Performed Previously

Exam	Provider's Name/Practice	Address or Cross Streets	Phone and Fax
Eye Exam			
Foot			

**Diabetic Supplies: \*\*\* Diabetic Patients' Only \*\*\***

Glucometer:	Test Strips:	Lancets:	Other:
Insulin Pump:	Infusion Set:	Reservoir:	Catridges:
DME Company Providing Supplies:			
Continuous Glucose Monitor (CGM):	Reader/Receiver:	Sensors:	Transmitter:
DME Company Providing Supplies:			

Did you bring any of the following with you today? (Please Check)

Blood Sugar Meter  Log Book  Insulin pump

Please bring your meter, log book, insulin pump and medication list to **all future appointments.**

**Family History:**  Check Here if No Family History  Check Here if Adopted and Unknown

Condition	Relation
<input type="checkbox"/> Celiac Disease	<input type="checkbox"/> Paternal <input type="checkbox"/> Maternal
<input type="checkbox"/> Cancer	<input type="checkbox"/> Paternal <input type="checkbox"/> Maternal

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<input type="checkbox"/> Diabetes Mellitus	<input type="checkbox"/> Paternal <input type="checkbox"/> Maternal
<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Paternal <input type="checkbox"/> Maternal
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Paternal <input type="checkbox"/> Maternal
<input type="checkbox"/> Hypertension	<input type="checkbox"/> Paternal <input type="checkbox"/> Maternal
<input type="checkbox"/> Hip Fracture	<input type="checkbox"/> Paternal <input type="checkbox"/> Maternal
<input type="checkbox"/> Iron Overload Disease	<input type="checkbox"/> Paternal <input type="checkbox"/> Maternal
<input type="checkbox"/> Obesity	<input type="checkbox"/> Paternal <input type="checkbox"/> Maternal
<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Paternal <input type="checkbox"/> Maternal
<input type="checkbox"/> Premature Menopause	<input type="checkbox"/> Paternal <input type="checkbox"/> Maternal
<input type="checkbox"/> Pancreatic Tumor or Cancer	<input type="checkbox"/> Paternal <input type="checkbox"/> Maternal
<input type="checkbox"/> Pituitary Tumor or Cancer	<input type="checkbox"/> Paternal <input type="checkbox"/> Maternal
<input type="checkbox"/> Stroke	<input type="checkbox"/> Paternal <input type="checkbox"/> Maternal
<input type="checkbox"/> Seizure	<input type="checkbox"/> Paternal <input type="checkbox"/> Maternal
<input type="checkbox"/> Thyroid Disease	<input type="checkbox"/> Paternal <input type="checkbox"/> Maternal
<input type="checkbox"/> Thyroid Cancer	<input type="checkbox"/> Paternal <input type="checkbox"/> Maternal
<input type="checkbox"/> ParaThyroid / Calcium Problem	<input type="checkbox"/> Paternal <input type="checkbox"/> Maternal
<input type="checkbox"/> Pheochromocytoma	<input type="checkbox"/> Paternal <input type="checkbox"/> Maternal

**Previous History of Steroid Use:** (Oral, Injections, Inhaled, Topical)  Check Here if No Previous History of Steroid Use

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**Social History:**

<b>Tobacco</b>	<input type="checkbox"/> Never Smoker <input type="checkbox"/> Former Smoker <input type="checkbox"/> Current Every Day Smoker <input type="checkbox"/> Current Some Day
<b>Smoking How Much</b>	<input type="checkbox"/> 1 Pack Per Week <input type="checkbox"/> 2 Packs Per Week <input type="checkbox"/> ¼ Pack Per Day <input type="checkbox"/> ½ Pack Per Day <input type="checkbox"/> 1 Pack Per Day <input type="checkbox"/> 1 ½ Pack Per Day <input type="checkbox"/> 2 Packs Per Day <input type="checkbox"/> 3+ Packs Per Day
<b>Smokeless</b>	<input type="checkbox"/> Never <input type="checkbox"/> Former <input type="checkbox"/> Current Snuff User <input type="checkbox"/> Currently Chews Tobacco <input type="checkbox"/> Current Moist
<b>E-Cigarette/Vape</b>	<input type="checkbox"/> Never <input type="checkbox"/> Current User <input type="checkbox"/> Former User

**Review of Systems:** (Please Mark All Current Symptoms That Apply)

<b>Constitutional:</b>			
<input type="checkbox"/> Fever	<input type="checkbox"/> Night Sweats	<input type="checkbox"/> Weight Gain / How Much:	<input type="checkbox"/> Weight Loss / How Much:
<input type="checkbox"/> Exercise Intolerance	<input type="checkbox"/> Lethargy	<input type="checkbox"/> Chills	<input type="checkbox"/> Malaise (General Discomfort)
<b>Eyes:</b>			
<input type="checkbox"/> Dry Eyes	<input type="checkbox"/> Irritation	<input type="checkbox"/> Vision Change	<input type="checkbox"/> Eye Disease / Injury
<b>Nose:</b>			
<input type="checkbox"/> Frequent Nose	<input type="checkbox"/> Nose Problems	<input type="checkbox"/> Sinus Problems	
<b>Mouth/Throat:</b>			
<input type="checkbox"/> Sore Throat	<input type="checkbox"/> Bleeding Gums	<input type="checkbox"/> Snoring	<input type="checkbox"/> Dry Mouth
<input type="checkbox"/> Oral Abnormalities	<input type="checkbox"/> Mouth Ulcers	<input type="checkbox"/> Teeth Abnormalities	<input type="checkbox"/> Mouth Breathing
<input type="checkbox"/> Ringing in Ears	<input type="checkbox"/> Sinusitis		

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<b>Cardiovascular:</b>			
<input type="checkbox"/> Chest Pain on Exertion	<input type="checkbox"/> Arm Pain on Exertion	<input type="checkbox"/> Shortness of Breath When Walking	<input type="checkbox"/> Shortness of Breath While Laying Down
<input type="checkbox"/> Palpitations	<input type="checkbox"/> Known Heart Murmur	<input type="checkbox"/> Light Headed on Standing	<input type="checkbox"/> Ankle Swelling
<b>Respiratory:</b>			
<input type="checkbox"/> Cough	<input type="checkbox"/> Wheezing	<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> Coughing Up Blood
<input type="checkbox"/> Sleep Apnea			
<b>Gastrointestinal:</b>			
<input type="checkbox"/> Abdominal Pain	<input type="checkbox"/> Nausea	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Constipation
<input type="checkbox"/> Change in Appetite	<input type="checkbox"/> Black or Tarry Stools	<input type="checkbox"/> Frequent Diarrhea	<input type="checkbox"/> Vomitting Blood
<input type="checkbox"/> Dyspepsia	<input type="checkbox"/> GERD		
<b>Genitourinary:</b>			
<input type="checkbox"/> Urinary Loss of	<input type="checkbox"/> Difficulty Urinating	<input type="checkbox"/> Increased Urinary Frequency	<input type="checkbox"/> Hematuria
<input type="checkbox"/> Incomplete			
<b>Musculoskeletal:</b>			
<input type="checkbox"/> Muscle Aches	<input type="checkbox"/> Muscle Weakness	<input type="checkbox"/> Arthraigias / Joint Pain	<input type="checkbox"/> Back Pain
<input type="checkbox"/> Extremity Swelling	<input type="checkbox"/> Neck Pain	<input type="checkbox"/> Difficulty Walking	<input type="checkbox"/> Cramps
<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Fractures		
<b>Integumentary:</b>			
<input type="checkbox"/> Abnormal Mole	<input type="checkbox"/> Jaundice	<input type="checkbox"/> Rash	<input type="checkbox"/> Itching
<input type="checkbox"/> Dry Skin	<input type="checkbox"/> Growths / Lesions	<input type="checkbox"/> Laceration	<input type="checkbox"/> Non-Healing Areas
<input type="checkbox"/> Changes in Hair /	<input type="checkbox"/> Psoriasis	<input type="checkbox"/> Changes in Skin Color	<input type="checkbox"/> Breast Lump
<b>Neurologic:</b>			
<input type="checkbox"/> Loss of	<input type="checkbox"/> Weakness	<input type="checkbox"/> Numbness	<input type="checkbox"/> Seizures
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Migraines	<input type="checkbox"/> Restless Legs	<input type="checkbox"/> Frequent / Severe Headaches
<input type="checkbox"/> Tremor	<input type="checkbox"/> Gait Dysfunction	<input type="checkbox"/> Paralysis	
<b>Psychiatric:</b>			
<input type="checkbox"/> Depression	<input type="checkbox"/> Sleep Disturbance	<input type="checkbox"/> Feeling Unsafe in Relationship	<input type="checkbox"/> Restless Sleep
<input type="checkbox"/> Alcohol Abuse	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Hallucinations	<input type="checkbox"/> Suicidal Thoughts
<input type="checkbox"/> Mood Swings	<input type="checkbox"/> Memory Loss	<input type="checkbox"/> Agitation	<input type="checkbox"/> Dementia
<b>Endocrine:</b>			
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Increased Thirst	<input type="checkbox"/> Hair Loss	<input type="checkbox"/> Increased Hair Growth
<input type="checkbox"/> Cold Intolerance			
<b>Hematologic/Lymphatic:</b>			
<input type="checkbox"/> Swollen Glands	<input type="checkbox"/> Easy Bruising	<input type="checkbox"/> Excessive Bleeding	<input type="checkbox"/> Anemia
<input type="checkbox"/> Phlebitis (Vein Inflammation)	<input type="checkbox"/> Jaundice	<input type="checkbox"/> Rash	<input type="checkbox"/> Itching
<b>Allergy/Immunologic:</b>			
<input type="checkbox"/> Runny Nose	<input type="checkbox"/> Sinus Pressure	<input type="checkbox"/> Itching	<input type="checkbox"/> Hives
<input type="checkbox"/> Frequent Sneezing			

### Patient Registration

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_

Date of Birth \_\_\_\_\_ SSN \_\_\_\_\_

Address \_\_\_\_\_ Apt/Unit \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Driver's License No \_\_\_\_\_ State Issued \_\_\_\_\_

Gender:  Male  Female

Primary Phone \_\_\_\_\_  Cell  Home  Work Is this your preferred phone?  Y  N

Secondary Phone \_\_\_\_\_  Cell  Home  Work Is this your preferred phone?  Y  N

Email address \_\_\_\_\_ (by providing your email you consent to use our patient portal)

Relationship Status: S M W D Other

Do you need an interpreter? Y / N

#### (Emergency Contact Information)

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

**Guarantor (if not patient)** Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_

Birthdate \_\_\_\_\_ SSN \_\_\_\_\_

Address \_\_\_\_\_ Apt/Unit \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

#### (Primary Insurance)

Insurance Name \_\_\_\_\_ ID# \_\_\_\_\_ Group# \_\_\_\_\_

#### Policy Holder (if not patient)

**Name** \_\_\_\_\_ **DOB** \_\_\_\_\_ **SSN** \_\_\_\_\_

#### (Secondary Insurance)

Insurance Name \_\_\_\_\_ ID# \_\_\_\_\_ Group# \_\_\_\_\_

#### Policy Holder (if not patient)

**Name** \_\_\_\_\_ **DOB** \_\_\_\_\_ **SSN** \_\_\_\_\_

I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original. I hereby authorize Arizona Diabetes & Endocrinology, PLC to apply for benefits on my behalf and I request that payment from my insurance company be made directly to Arizona Diabetes & Endocrinology, PLC for medical benefits otherwise payable to me. **I understand that I am financially responsible for charges not covered by my insurance.** I hereby certify that the information I have reported with regard to my insurance coverage is correct.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

## HIPAA and Release of PHI

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_ DOB: \_\_\_\_\_

I Do  I Do NOT give my permission for AZDNE to leave messages regarding my lab results, treatment, diagnosis, appointments, billing/payments, and any other pertinent information regarding my care at the following number(s):

Mobile Number \_\_\_\_\_ Home Number \_\_\_\_\_

Do you consent to receive automated **email** messages from our office? Yes / No

Do you consent to receive automated **phone** messages from our office? Yes / No

Do you consent to receive automated **text** messages from our office? Yes / No

By signing below, I acknowledge that I have received the Notice of Privacy Practices of AZDNE which explains its legal duties and privacy practices with respect to my Protected Health Information (PHI). I understand that I may refuse to sign this acknowledgement. I authorize AZDNE to disclose my PHI as specified below to the individuals listed below.

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Information to be released (circle): ALL / Treatment / Diagnosis / Appointment / Billing / Other \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Information to be released (circle): ALL / Treatment / Diagnosis / Appointment / Billing / Other \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Information to be released (circle): ALL / Treatment / Diagnosis / Appointment / Billing / Other \_\_\_\_\_

The above authorizations shall remain in effect until I provide Arizona Diabetes & Endocrinology, PLC with written revocation. I understand I cannot revoke this authorization retroactively for information already released. I understand when Arizona Diabetes & Endocrinology, PLC discloses PHI pursuant to this authorization, they can no longer guarantee confidentiality or prevent re-disclosure and the information may no longer be protected by federal privacy rules. I understand by signing this authorization I agree to allow Arizona Diabetes & Endocrinology, PLC and its staff to disclose the protected health information to the above stated person(s) and/or entity.

Patient or legally authorized representative Signature \_\_\_\_\_ Date \_\_\_\_\_

Printed name if signed on behalf of the patient \_\_\_\_\_ Relationship \_\_\_\_\_

### FOR OFFICE USE ONLY

I, \_\_\_\_\_ (Employee Name), made a good faith effort to obtain written acknowledgement of the receipt of the Notice of Privacy Practices of AZDNE for the above-named patient. I was unable to obtain written acknowledgement due to the following reason:

Individual refused to sign  Communication barrier  An emergency situation  Other \_\_\_\_\_

## *Office and Financial Policies*

**OFFICE & PHONE HOURS:** Our office is open Monday through Thursday from 8:00AM-5:00PM and Friday from 8:00AM-12:00PM. Our phone lines close for lunch from 12:00-1:00. Phone lines are not open past noon on Friday.

**LAB HOURS:** We will offer in-office phlebotomy services Monday through Thursday from 8:00AM-11:30AM and 1:00PM-4:30PM as well as Friday from 8:00AM-11:30AM. We do not draw outside orders unless they are presented in conjunction with an order from one of our providers. **Lab Services are by appointment Only.**

**APPOINTMENT ARRIVAL and CONFIRMATION/CANCELLATION:** We require **ALL new patients to arrive 30 minutes prior to their scheduled time.** This allows our clinical staff to perform intake and minimize the wait time for all patients. If you arrive more than 10 minutes late your appointment will be rescheduled at the provider's discretion. **IF YOU NO SHOW OR CANCEL YOUR APPOINTMENT WITHIN 24 HOURS, YOU WILL BE CHARGED A \$50 FEE.** \_\_\_\_\_ (Initials)

If the provider has ordered bloodwork, please have this done 1-2 weeks prior to your appointment. **If the results are not in our office 72 hours prior to your visit we will cancel your appointment.** \_\_\_\_\_ (Initials)

**INSURANCE:** We only bill for services rendered by Arizona Diabetes & Endocrinology. If you would like us to bill your medical insurance, **you must present a current insurance card to our receptionist each time you visit our office.** If we do not have a valid card on file or are unable to verify your eligibility, payment of our cash fee will be expected at the time of service. If your insurance denies payment you are financially responsible for the balance due. Questions regarding claim payment should be directed to your insurance company directly. \_\_\_\_\_ (Initials)

**REFERRALS:** If your insurance company requires a referral to see a specialist, the referral must be on file in our office in order for you to be seen by the provider. **It is your responsibility to ensure we have a valid referral** including a referral number (if required by insurance) as well as a valid number of visits and current date range authorized by your primary care physician. You will be asked to reschedule your appointment if we do not have a valid referral at the time of check-in. . \_\_\_\_\_ (Initials)

**COPAYS:** If your insurance plan requires a copay, it is due at the time of your visit. \_\_\_\_\_ (Initials)

**OUTSTANDING ACCOUNT BALANCE:** Your account balance must be paid in full prior to seeing the provider. If you are unable to pay your balance you may ask to setup a payment plan. If you default on the payment plan, your account will be sent to our collection agency and we will not be able to schedule future appointments. \_\_\_\_\_ (Initials)

**COLLECTION ACCOUNTS and RETURN CHECK FEE:** Accounts that are 90 days past due will be sent to an external collection agency and the patient will be discharged from our practice for non-payment. A fee of \$30 will be assessed for any returned check. \_\_\_\_\_ (Initials)

**PRESCRIPTION REFILLS:** Prescription refill requests should be directed to your pharmacy. Requests will be processed within 48-72 hours. It is the patient's responsibility to plan ahead for refills as we do not guarantee a same-day response. **Refills will not be given to patients who do not attend regularly scheduled appointments.** \_\_\_\_\_ (Initials)

**LAB ORDERS:** Lab orders are sent electronically to the preferred lab in accordance with your insurance. Please contact the draw station directly in order to verify whether or not your order is on file. We do not send lab orders through the mail.

**ON-CALL SERVICES:** A provider will be on-call after business hours for emergencies only. Prescription refills **WILL NOT** be addressed by the on-call provider. Please plan ahead to ensure you are requesting refills before running out of your medication(s). \_\_\_\_\_ (Initials)

I have read the above policies and I agree to abide by them. I understand policies may change without notice and it is my responsibility to seek updated information from the practice website or material posted in the office.

Name \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

## *Authorization for Release of Medical Information*

Patient Name (Please Print): \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Obtain Information From **OR**  Release Information To  
**Mark One Selection:** Physician Facility Self Other

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Address: \_\_\_\_\_

**Information to be Released:**

- Complete Records
- Progress Notes
- Lab/X-Ray Reports
- Whole Body Scan
- Billing Information
- Biopsy/Pathology Report
- Surgical Report
- Other: \_\_\_\_\_

**Information to be Restricted:**

- The patient restricts the release of the following:
- Behavior & Mental Health Records
  - Communicable Diseases (including HIV/AIDS)
  - Alcohol & Drug Abuse Treatment
  - Genetics  Other

**Form and Method of Release:**

Records should be sent by  Hard Copy/Paper  Soft Copy/Electronic Format

Mail to address above  Fax to number above  Notify patient to pick-up when ready

**(Requests containing more than 30 pages must be picked up or mailed in electronic format)**

**Service Dates:**

All Dates **OR**  From \_\_\_\_\_ to \_\_\_\_\_

**Purpose of Release:**

- Treatment/Continuity of Care
- Transfer of Medical Care
- Insurance Coverage
- Disability Determination
- Legal Purposes
- Moving
- Personal
- Other: \_\_\_\_\_

This authorization will expire one (1) year from the date of signing, or as indicated here: \_\_\_\_\_ and may be revoked at any time by providing written notice of revocation. I understand I cannot revoke this authorization retroactively for information already released. I understand when Arizona Diabetes & Endocrinology, PLC discloses PHI pursuant to this authorization, they can no longer guarantee confidentiality or prevent re-disclosure and the information may no longer be protected by federal privacy rules. I understand by signing this authorization I agree to allow Arizona Diabetes & Endocrinology, PLC and its staff to disclose the protected health information to the above stated person(s) and/or entity. I understand my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this form.

**Signature:** \_\_\_\_\_ **Date Signed:** \_\_\_\_\_

**Printed Name of Person Signing (if not patient):** \_\_\_\_\_