MRN# _____

accent Endocrinology
4340 Newberry Rd, Suite 103, Gainesville, FL 32607
Phone: 352 372-9414 Fax: 352 271-5393

NEW PATIENT MEDICAL HISTORY

NAME _____ AGE _____ DOB _____ DATE _____

REASON FOR VISIT: _____ HOW LONG HAS IT BOTHERED YOU? _____

Primary Care Physician: _____

List Other Physicians you see and why: _____

PERSONAL MEDICAL HISTORY - CONDITIONS THAT APPLY TO YOU:

	Yes	No	Year		Yes	No	Year
Diabetes Mellitus	❑	❑		Hypothyroidism (low thyroid)	❑	❑	
High Blood Pressure	❑	❑		Hyperthyroidism (high thyroid)	❑	❑	
High Cholesterol	❑	❑		Goiter or Thyroid Nodules	❑	❑	
Heart Disease	❑	❑		Thyroid Cancer	❑	❑	
Stroke	❑	❑		Osteoporosis	❑	❑	
Impaired Hearing	❑	❑		Frequent Falls or Balance Issues	❑	❑	
Impaired Vision	❑	❑		Fractures: if yes please list site below	❑	❑	
Nerve Damage (neuropathy)	❑	❑		High Calcium	❑	❑	
Liver Disease	❑	❑		Kidney Stones	❑	❑	
Kidney Disease	❑	❑		Heart Burn/Acid Reflux (GERD)	❑	❑	

List other Medical Conditions, fractures or recent Hospitalizations:

HEALTH MAINTENANCE: If you have had any of the following done, please indicate when it was most recently done (Month/Year):

Flu Vaccine:	Bone Density Scan (DXA):
Pneumonia Vaccine:	Dilated Eye Exam:

SURGERIES - YOU HAVE HAD	DATE	REASON/COMPLICATIONS
1.		
2.		
3.		
4.		

PERSONAL SOCIAL HISTORY:

Occupation: Yours: _____ Spouses': _____

Place of Employment: _____

Education (circle level completed): High School 9 10 11 12 College 1 2 3 4 Masters PhD Other

Marital Status: (circle) Single Married Widowed Separated Divorced

Who lives at home with you? _____

Exercise: What type of exercise do you get? (circle please)
Walking jogging bicycling swimming golf tennis other _____

_____ Minutes each day?
_____ Days per week?

_____ Moderate occupational or recreational exercise?
_____ Sedentary work and light exercise only?

NAME: _____ MRN: _____ DATE: _____

Do **YOU** use currently (or in the past) any of the following products?

Yes	No	Product	Amount	How Long	When Quit
		Cigarettes			
		Cigars			
		Chewing tobacco			
		Alcohol			
		Caffeine			
		Street Drugs			

ABOUT YOUR FAMILY:

If yes whom?
(M=mother, F=father, B=brother, A=aunt, U=uncle, S=sister, GM=grandmother, GF=grandfather, C=child)

	Yes	No			Yes	No	
Cancer (type)	❑	❑		Hip Fracture before age 80yrs	❑	❑	
				Kidney Failure	❑	❑	
Diabetes Mellitus	❑	❑		Kidney Stones	❑	❑	
High Blood Pressure	❑	❑		Obesity	❑	❑	
High Cholesterol	❑	❑		Strokes	❑	❑	
Heart Disease	❑	❑		Elevated Thyroid (hyperthyroid)	❑	❑	
Heart Attack/MI	❑	❑		Low Thyroid (hypothyroid)	❑	❑	
Strokes	❑	❑		Enlarged Thyroid (Goiter)	❑	❑	
Elevated Calcium	❑	❑		Thyroid Cancer	❑	❑	
Osteoporosis	❑	❑					

Other: _____

FEMALES ONLY:

1. At what age was your first menstrual period? _____ Number of periods in the last year? _____
2. When was your most recent period? _____ Longest time between periods (days/months) _____
3. Are your periods regular? _____
4. # of Pregnancies: _____ # of Miscarriages: _____ Birthweight of largest baby: _____
5. If applicable, what was your age at menopause? _____ Did you receive hormone therapy? _____ How Long? _____
6. Date (year) of last mammogram _____

Name _____ MRN: _____ DATE: _____

REVIEW OF SYMPTOMS: (Check all that apply to **YOU CURRENTLY**)

GENERAL: ❑ Fatigue ❑ Fever ❑ Night sweats ❑ Nausea ❑ Vomiting ❑ Appetite Loss ❑ Appetite Gain ❑ Persistent Infections ❑ Weight Loss ❑ Weight Gain ❑ None of the above	SKIN: ❑ Easy Bruising ❑ Rash ❑ Itching ❑ Hair Loss ❑ Nail changes ❑ Dryness ❑ Increased Hair Growth ❑ Ulcers ❑ Purple stretch marks ❑ None of the above	EYES/EARS ❑ Blurred Vision ❑ Double Vision ❑ Eye Pain ❑ Puffiness around the eye ❑ Eye Glasses/Contacts ❑ Visual Loss ❑ Ear drainage ❑ Ear pain ❑ Dizziness ❑ Hearing loss ❑ None of the above	NOSE ❑ Loss of taste or smell ❑ Postnasal drip ❑ Hayfever ❑ Stop breathing at night THROAT ❑ Difficulty swallowing ❑ Hoarseness ❑ Swollen glands ❑ None of the above
NECK ❑ Neck pain ❑ Neck swelling ❑ None of the above	RESPIRATORY ❑ Shortness of breath ❑ Sleep apnea ❑ Wheezing ❑ Cough ❑ Snoring ❑ Sputum Production ❑ None of the above	BREAST ❑ Breast Mass ❑ Breast Pain ❑ Male Breast Enlargement ❑ Nipple Discharge ❑ None of the above	HEART/CIRCULATION ❑ Chest pain or pressure ❑ Palpitations ❑ Heart Murmur ❑ Irregular Heart Beat ❑ Pain in legs with walking ❑ Swelling of hands or feet ❑ None of the above
GASTROINTESTINAL ❑ Heartburn ❑ Abdominal pain ❑ Constipation ❑ Diarrhea ❑ Jaundice ❑ Gets full quickly at meals ❑ None of the above	GENITOURINARY FOR WOMEN ❑ Kidney Stones ❑ Frequent Urination ❑ Frequent urination at night ❑ Urgency with urination ❑ Pain with urination ❑ Absence of menstruation ❑ Menstrual Irregularities ❑ Vaginal dryness ❑ Change in sex drive ❑ None of the above	GENITOURINARY FOR MEN ❑ Kidney Stones ❑ Frequent Urination ❑ Frequent urination at night ❑ Urgency with urination ❑ Change in urinary stream ❑ Change in sex drive ❑ Difficulty with erections ❑ Testicular mass ❑ None of the above	MUSCULOSKELETAL ❑ Back Pain ❑ Joint pain ❑ Muscle pain ❑ Muscle weakness ❑ Muscle cramps ❑ Change in glove, hat or shoe size ❑ None of the above
NERVOUS SYSTEM ❑ Fainting spells ❑ Headaches ❑ Decreased Memory ❑ Numbness ❑ Tingling ❑ Tremor ❑ Unsteadiness ❑ None of the above	PSYCHIATRIC ❑ Depression ❑ Mood Swings ❑ Anxiety ❑ Insomnia ❑ Crying spells ❑ None of the above	ENDOCRINE ❑ Heat intolerance ❑ Cold intolerance ❑ Excessive sweating ❑ Excessive thirst ❑ Excessive urination ❑ None of the above	BLOOD ❑ Anemia ❑ History of transfusions ❑ Sickle Cell Anemia ❑ Abnormal bleeding ❑ None of the above

What additional information should the doctor have about you? _____

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Ear, Nose & Throat
- Ann Glowasky, MD
- Jeffrey Phillips, MD
- Brian Kerr, MD
- Daniel J. Hall, MD, FACS
- Alex Rafanan, PA-C

Endocrinology
- Sandra Werbel, MD
- Sadaf Jeelani, MD
- Colleen Digman, MD
- David Kireta, P.A.-C
- Renee Berens, P.A.-C

Facial Plastic Surgery
- Daniel J. Hall, MD, FACS

Audiology
- Ryan Baker, Au.D
- Diana Guercio, Au.D
- Steven Petrakis, Au.D
- Ashley Espinosa, Au.D

Aesthetics
- Mary Hazen, P.A.-C

Thyroid Disorders
Eye Surgery
Otology
Hearing & Balance Disorders
Nose & Sinus Care
Laryngeal
Voice & Swallowing Disorders
Facial Plastic Surgery
Diabetes Management
Audiology
Head & Neck Surgical Oncology
ENT Allergy
Aesthetics

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Gainesville, Florida 32607
Phone: (352)372-9414
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accentmd.com

No Show Policy

MR# _____

Accent Physician Specialists asks for 48 hours notice if you cannot come for your visit. Failure to come to your appointment or cancel it will result in a $50.00 charge. We will make an exception to this policy if your appointment time is less than 48 hours from the time we scheduled it. In this instance, we will only require 24 hours notice. If you have two appointments, one with the doctor and one for testing such as audiology or ultrasound, the fee will be $50 per appointment, resulting in a $100 charge.

If you are more than 15 minutes late for your appointment, we will reschedule your appointment for a later date.

This is not a policy that we prefer, but our survival as a practice depends on our patients being good partners as we try to provide the best healthcare that we can.

I have read and acknowledge the above policy.

_____

Signature Print Name Date

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Authorization to Release Insurance and Medical Information

Patient Name: _____

Date of Birth: _____ Sex: M F

Mailing Address: _____ Apt. #:_____

City: _____ State: _____ Zip: _____

Best Phone #: _____ Cell Phone: _____

Parent/Guardian Name: _____

Date of Birth: _____

Mailing Address: _____ Apt. #:_____

City: _____ State: _____ Zip: _____

E-mail address: _____

Primary Care Physician: _____ Referred By: _____

Insurance Information

Primary Insurance: _____Policy ID#_____

Policy Holder's Name: _____

DOB: _____

Policy Holder's Address: _____

City: _____ State: _____ Zip Code: _____

Secondary Insurance: _____

Policy Holder's Name: _____Policy ID#_____

DOB: _____

Policy Holder's Address: _____

City: _____ State: _____ Zip Code: _____

Emergency Contact: _____**Relationship**: _____ **Phone**:_____

I authorize Accent Physician Specialists to provide the treatment deemed necessary to care for the above named patient. I authorize the release of medical records and information to or from any medical practice or insurance plan concerning the diagnosis, treatment, and determination of care.

_____

SIGNATURE OF PATIENT/PARENT OR GUARDIAN DATE

ASSIGNMENT OF BENEFITS AND FINANCIAL RESPONSIBILITY

As a courtesy, Accent Physician Specialists, P.A. will file my insurance claim. Insurance payment for services and treatment are directed to Accent Physician Specialists, P.A. I understand that payment for services rendered and supplies provided is ultimately my responsibility and payment is due when billed, whether or not my insurance company had paid.

I hereby authorize the insurance carrier with whom I have a policy to pay benefits directly to Accent Physician Specialists, P.A. for rendered services. I agree to pay all charges that are not paid in full by my assigned insurance. In the event that I default on payment of my account, I agree to be held responsible for all fees, which could be 40% of the total amount due as well as the interest accrued on the amount in default, court costs and reasonable attorney fees.

I have received, read and understood the Accent Physician Specialists, P.A. Assignment of Benefits and Financial Responsibility statement above._____ (Please Initial)

H.I.P.A.A. Notice of Privacy Practices

I have received, read and understood the Accent Physician Specialists, P.A. H.I.P.A.A. Notice of Privacy page._____ (Please Initial)

Notice of Release of Information

In case of emergency, please list any parties you authorize access to health information. Understand that *only* the parties listed below are authorized to receive knowledge of your treatment, medications, appointments or surgery. This list may be revoked at anytime by notifying Accent Physician Specialists, P.A. in writing.

Name	Relationship	Phone Number

Please list the person(s) that you give consent and/or authorize to bring your minor child to his/her appointment(s) at Accent Physician Specialists. This includes them being able to sign for your minor child to receive treatment. This does **NOT** include surgery consent forms. **A parent or court appointed legal guardian MUST be present at the pre-op appointment to sign surgical consent forms.**

Name	Relationship	Phone Number

_____ _____

SIGNATURE OF PATIENT/PARENT OR GUARDIAN DATE

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Medication, Pharmacy and Allergy Information

Name: _____ Date of Birth: _____ Date: _____

Pharmacy Name: _____ Pharmacy Number: _____

	Medication	Dose	How Often	Reason Why
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				
16				
17				
18				
19				
20				

	Allergy	Reaction
1		
2		
3		
4		
5		
6		
7		