Dr. Mohammed Ansari, MD

Patient Registration Form

Whom may we thank for your referral? ____

Phone________________________ Other________________________
PCP_________________________

Patient Information

Patient Name______________________________ DOB____/____/_____ Age__________ Sex F M (circle)

Phone__________________Cell____________________ SSN_____-_____-_____ Marital Status____________

Address_______________________________________City____________________State_______Zip_________

Employer Name____Phone________________________________

Emergency Contact____Phone_____________________________

EMAIL: _______________________________________ **Preferred Language:** ________________________

Ethnicity: ☐ **Hispanic or Latino** ☐ **Other** **Student Status:** ☐ **Full Time** ☐ **Part Time**

Race: ☐ **American Indian or Alaska Native** ☐ **Asian** ☐ **Black or African American**

☐ **Native Hawaiian or Pacific Islander** ☐ **White** ☐ **Other**

Primary Insurance Information

Primary Insurance Name____

Name of insured_______________________________ Phone___________________ DOB____/____/____

SSN______-_______-_______ Insurance ID Number __________________Group Number_____________

Address____________________________City_____________________State__________Zip__________

Relationship to patient_____________________

Secondary Insurance Information

Secondary Insurance Name____

Name of insured____________________________ Phone___________________ DOB____/_____/_____

SSN_____-______-______ Insurance ID Number ____________________Group Number_______________

Address____________________________City_____________________State__________Zip___________

Relationship to patient____

_______________________ _______________________ _______________________

Reviewed by Date Patient #/ Doctor #

Terms of Agreement

Please INITIAL after each term of agreement

- ***Complete Endocrine Care*** has the right to release confidential medical information to other parties involved in my care including my insurance carrier, my referring physician and/or my primary physician. ______

- If my insurance requires a referral and I do not obtain one in advance of my appointment, I will be required to make payment in full or reschedule my appointment. ______

- I understand and agree that I am financially responsible for all in-network and/or out-of-network balances owed to ***Complete Endocrine Care*** as assigned by my insurance carrier. ______

Acknowledge Of Receipt of Notice of Privacy Practices

I acknowledge that I have been given an opportunity to review the Notice of Privacy Practices from ***Complete Endocrine Care*** and that I may request a copy for my records if I so choose.

____ ______________________
Signature of Patient or Legal Representative Date

____ ______________________
Print Name of Patient or Legal Representative Date

Acknowledgement and Authorization to Treat

I hereby acknowledge the information given is true to the best of my knowledge and I understand the terms and agreements made with ***Complete Endocrine Care.***

I, ________________________Legal Guardian/Parent/Self, authorize medical treatment by a staff physician associated with, ***Complete Endocrine Care***.

____Date______/______/_____
Patient or Legal Representative Signature

Responsible Party Name_______________________________DOB___/____/____SS#______-______-______

________________________ ________________________ ________________________
Reviewed by Date Patient #/ Doctor #

Complete Endocrine Care
Thyroid • Diabetes • Metabolic disorders

Mohammed Ansari, MD

Initial Patient Visit Form Date____________________

Name: First______________________M.I.__________Last____________________

For Minor Children:

Mother's Name ____

Father's Name ____

What problem are you seeing the doctor for? ____________________________________

Hand Dominance _________Right _________Left _________Both/Ambidextrous

____

Have you had any previous treatment for this condition? ☐ Yes ☐ No If yes, what doctor did you see and when?

____

Medications:
Please list your Pharmacy information and all medications, including doses (if known) that you are currently taking. Include over the counter drugs, herbs, vitamins, etc.

Pharmacy	Address	Phone Number

Medication	Dose	Frequency

Allergies**Please list all allergies: include medications, foods (shellfish, nuts, etc), materials (tape and latex products, etc) and other substances. If none, please write "None".	Reaction

Complete Endocrine Care
Social History, Family History

Social History:

Do you drink alcohol?

Yes, Rarely (< 1/month) Occasionally (1-4/month) Socially (1-2/week) Frequently (3-5/week) Daily

No, Used to but stopped (date) _____________________ Never used alcohol

How often do you exercise?

Never Rarely (< 1/month) Occasionally (1-4/month) Frequently (3-5/week) Daily

Do you smoke tobacco products? (Required for all patients 13 years and older)

Yes, I currently smoke. I smoke __________packs per day and have smoked for _______years.
No, but I used to smoke. I smoked __________packs per day for __________years and quit ___________.
No, I have never smoked

Do you have a Special Diet? No Yes (describe) ____

Do you use controlled or illegal substances?

Yes, Rarely (< 1/month) Occasionally (1-4/month) Socially (1-2/week) Frequently (3-5/week) Daily

No, Used to but stopped (date) _____________________ Never used drugs

Which drugs do/did you use? Cocaine Marijuana other ________________

Family history:

Has anyone in your *immediate family* ever had any of the following? (Mark all that apply)
Please specify who the history applies to: Mother, father, sister, brother, grandmother, or grandfather.

None known
alcoholism
anxiety/depression
asthma
bleeding/clotting problems
cancer
colitis
coronary artery disease
diabetes
high blood pressure
high Cholesterol
hypothyroidism
leukemia
rheumatic Fever
seizure disorder
stroke
tuberculosis
other ________________

Serious Illnesses and Hospitalizations:

Please list all serious illnesses and/or hospitalizations along with any complications:

Illness or Reason for Hospitalization	**Year**	**Complications? (describe)**

Operations:

Please list all previous operations along with any complications:

_________________________ Reviewed by

_________________________ Date

_________________________ Patient #/ Doctor #

Complete Endocrine Care
Review of Systems Pertaining to the Patient

BP: ______/________

HT: ______________

WT: ______________
For Office Use Only

Have *you* had or are *you* currently having problems with any of the following?
Please mark with a √ yes or no and describe all YES responses.

Problems	**Yes**	**No**	**Description**
Blackouts/fainting			
Bleeding/Clotting			
Blood Transfusions			
Bone/ Muscle			
Cancer			
Colon			
Diabetes			
Digestion/GI			
Ears, nose, throat			
Epilepsy/Seizures			
Eyes			
Fever, Chills, Night sweats			
Hay fever/Allergies			
Heart: chest pain, irregular rhythms, palpitations, etc.			
Hepatitis A, B, C			
High blood pressure/Hypertension			
High Cholesterol			
HIV			
Kidney/Bladder			
Loss of balance/dizziness			
Low blood pressure			
Lung, Breathing			
Neuropathy			

Numbness/Tingling			
Polio			
Prostate enlargement			
Psychological			
Seizures			
Skin/Breast			
Thyroid			
Other:			

I understand that any person who knowingly and with intent to defraud any insurance company or other persons, files a statement of claim containing any materially false information or who conceals, for the purpose of misleading, information concerning any fact, commits a fraudulent act, which is a crime subject to criminal prosecution and civil penalties.

_______________________________________ _______________________ __________

Signature of patient, parent or guardian (if minor) Date Chart #

For Office use only:

Physician	Date	Physician	Date	Physician	Date