WINCHESTER ENDOCRINOLOGY
172 Linden Drive, Suite 103 • Winchester, VA 22601
(540) 678-0767
www.winendocrine.com

Patient Demographic Insurance Information

Basic Patient Information

Name of Patient: _____
First Middle Last

Street Address: _____

City: _____ State: _____ Zip: _____

Birth Date: _____ SSN: _____ Gender: ○F ○M

Home: (___) _____ Cell: (___) _____ Work: (___) _____

Email: _____

Billing Information / Responsible Party / Guarantor for Encounter

Responsible Party: _____
(If different from patient) First Middle Last

Street Address: _____

City: _____ State: _____ Zip: _____

Birth Date: _____ SSN: _____ Gender: ○F ○M

Home: (___) _____ Cell: (___) _____ Work: (___) _____

Responsible Party's Employer: _____

Insurance Coverage - Primary

Please present your insurance card & drivers license to the front desk when returning this form

Name of Insurance: _____

Policy / ID Number: _____ Effective Date: _____

Group Name: _____ Group Number: _____

Co-Pay Amount for Specialist: _____

Patient's Relationship to Policyholder: ○Self ○Child ○Spouse ○Guardian ○Other

Name of Policyholder: _____
(If different from responsible party) First Middle Last

Birth Date: _____ SSN: _____ Gender: ○F ○M

Home: (___) _____ Cell: (___) _____ Work: (___) _____

Name of Policyholder's Employer: _____

Address of Insurance Holder: _____

City: _____ State: _____ Zip: _____

Insurance Coverage - Secondary

Name of Secondary Insurance: _____

Policy / ID Number: _____ Effective Date: _____

Group Name: _____ Group Number: _____

Co-Pay Amount for Specialist: _____

Patient's Relationship to Policyholder: ○Self ○Child ○Spouse ○Guardian ○Other

Name of Policyholder: _____
(If different from responsible party) First Middle Last

Birth Date: _____ SSN: _____ Gender: ○F ○M

Name of Policyholder's Employer: _____

Address of Insurance Holder: _____

City: _____ State: _____ Zip: _____

Additional Patient Information

Did you bring the written referral from your referring physician? ○Yes ○No

Referring Physician: _____

Primary Care Physician: _____

Emergency Contact Information

Name: _____ Relationship to Patient: _____

Home: (___) _____ Cell: (___) _____ Work: (___) _____

Street Address: _____

City: _____ State: _____ Zip: _____

Financial Responsibility Agreement & Consent to Treat

I/We hereby authorize Winchester Endocrinology to furnish all information regarding my medical history, diagnosis and treatment of myself or my child (if applicable) to an insurance company regarding my claims for benefits. If however, said insurer fails to meet this obligation in whole or in part, or if I am non-insured, I/We agree to be responsible for the fee and cost involved in the treatment of the above named patient. I/We authorize payment of medical benefits to Winchester Endocrinology and further understand that should my account have to be referred to an attorney for collection that I am responsible for all fees and costs incurred therein. IN ALL CASES, PROFESSIONAL FEES ARE THE PATIENT, SPOUSE, GUARDIAN AND/OR PARENTS' RESPONSIBILITY. Finance charge (no charge if paid in 30 days of billing date) is computed by a "Periodic rate" of 1 1/2% per month, which is an ANNUAL PERCENTAGE RATE of 18% applied to the previous balance without deducting current payments and/or credits appearing on any given bill. Patient or responsible party(ies) further agree to pay any and all collection fees incurred and legal expenses, including but not limited to all collection Agency and Attorney feed, all court related costs, service and filing fees, interrogatory and garnishment fees as well as any interest that may be adjudicated for the collection of past due debts. I/We authorize Winchester Endocrinology to act on my behalf in accessing hospital records when and if needed.

I/We hereby authorize the providers in charge of my care and Winchester Endocrinology to perform upon me such technical procedures, administer such drugs, and render such medical care as their judgment may indicate as necessary or advisable. I understand that no guarantee has been made as to the results that may be obtained.

Print Name: _____ Signature: _____ Date: _____

Print Name: _____ Signature: _____ Date: _____
Second responsible party if applicable

Patient History

Patient Name: _____

What is you reason for coming today:

- ☐ Diabetes
- ☐ Thyroid
- ☐ Other Endocrine Disease

Describe you chief complaint: _____

_____

_____

_____

_____

Past Medical History

Please check if you are currently receiving treatment or have received treatment in the past for any of the following conditions:

☐ Diabetes Mellitus Type I	☐ Graves Disease	☐ Adrenal Tumor	☐ Hypertriglyceridemia
☐ Diabetes Mellitus Type II	☐ Thyroid Cancer	☐ Osteoporosis	☐ Coronary Artery Disease
☐ Goiter	☐ Pituitary Tumor	☐ Hypertension	☐ Stroke
☐ Thyroid Nodule	☐ Hypopituitarism	☐ Heart Attack	☐ Adrenal Insufficiency
☐ Hyperthyroidism	☐ Hyperparathyroidism	☐ Kidney Stones	☐ Peripheral Vascular Disease
☐ Hypothyroidism	☐ Hypercholesterolemia		

☐ Other (please specify): _____

Please list all previous operations:

Surgery	Approximate date of last surgery
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Drug Allergies

Please check any of the following drugs/substances to which you have had a reaction and describe what occurred:

☐ Penicillin	☐ Hay fever	☐ Molds
☐ Sulfa Drugs	☐ Eczema	☐ Latex
☐ Anesthesia	☐ Pollen	☐ Foods: _____
☐ Narcotics	☐ Dust	☐ Other: _____
☐ Blood	☐ Insects	_____
☐ Radioactive Contrast (Dye)	☐ Animals	☐ No Allergies

Patient Social History

Marital Status: ◯ Single ◯ Married ◯ Divorced ◯ Separated ◯ Widowed

Employment Status: ◯ Full-Time ◯ Part-Time ◯ Retired ◯ Student ◯ None

Occupation: _____

Use of tobacco: ◯ Never ◯ Previously Quit Date Quit: _____

◯ Current Smoker / Packs per day: _____ ◯ Oral Tobacco Use

Use of alcohol: ◯ Never ◯ Rarely ◯ Daily Intake (amount): _____

Exercise Type: _____ Frequency: _____

Diet: _____

Family History

Please check if you or a family member have has any of the following:

Condition	Father	Mother	Other (please specify)
Diabetes Mellitus	☐	☐	
Thyroid Disease	☐	☐	
Heart Disease	☐	☐	
Stroke	☐	☐	
Hypertension	☐	☐	
High Cholesterol	☐	☐	
Kidney Disease	☐	☐	
Cancer	☐	☐	
Osteoporosis	☐	☐	
Pituitary Problem	☐	☐	
Alcoholism	☐	☐	
Mental Illness	☐	☐	
Early Death	☐	☐	
Goiter	☐	☐	
Genetic Disease	☐	☐	
Birth Defects	☐	☐	
Bleeding Problems	☐	☐	
Chronic Disabling Disease	☐	☐	
Deafness before age 5	☐	☐	
Allergies	☐	☐	
Multiple Births	☐	☐	

OB History

Currently Pregnant? ◯ Yes ◯ No If yes, how many weeks? _____

Recently Pregnant? ◯ Yes ◯ No If yes, date of last pregnancy: _____

Planning to become pregnant? ◯ Yes ◯ No

Previous Pregnancies? Vaginal Deliveries (how many)? _____ Dates: _____

Cesarean Sections (how many)? _____ Dates: _____

Medications

If you are taking any prescription or over the counter medications, please list them below:

Medication	Dosage / Frequency	Length of time you've been taking it

Patient Questionnaire

Name: _____ Date: _____

To assist the provider in evaluating your case, please check the "YES" column only if you have any of the following conditions listed below. Further details need not be given until you see the provider. Please leave the right column blank for the provider's use. Thank you.

Do you have any of the following now:	YES	Please leave blank
GENERAL:		
Loss if appetite	☐	
Recent change in weight	☐	
Feelings of fatigue	☐	
Difficulty sleeping	☐	
Feelings of depression or anxiety	☐	
Fever / Night sweats	☐	
Heat intolerance	☐	
Cold intolerance	☐	
Changes in appearance	☐	
NERVOUS SYSTEM:		
Headache	☐	
Seizure / Passing out	☐	
Dizziness	☐	
Depression / Anxiety / Mental illness	☐	
SKIN:		
Rash	☐	
Dryness	☐	
Itching	☐	
Bruising / Poorly healing sores	☐	
Changes in pigment	☐	
HAIR:		
Hair loss	☐	
Increase of hair growth	☐	
Texture change	☐	
EYES:		
Vision changes	☐	
Eye redness / Irritation	☐	
Double vision	☐	
Eye swelling	☐	
Bulging eyes	☐	
EARS, NOSE & THROAT:		
Hearing loss	☐	
Ringing in ears	☐	
Vertigo	☐	
Hoarseness	☐	

Do you have any of the following now:	YES	Please leave blank
NECK:		
Goiter	☐	
Neck pain	☐	
HEART / LUNG		
Chest pain	☐	
Palpitations / Heart flutters	☐	
Shortness of breath	☐	
Short of breath at night	☐	
Wheezing	☐	
Cough / Sputum production	☐	
GASTROINTESTINAL:		
Nausea / Vomiting	☐	
Abdominal pain	☐	
Yellow skin or eyes	☐	
Change in bowel habits	☐	
Blood in stools or black stools	☐	
GENITOURINARY:		
Frequent urination	☐	
Getting up at night to urinate	☐	
Burning on urination	☐	
Blood in urine	☐	
Kidney stones	☐	
Change in libido / Sex drive	☐	
EXTREMITIES:		
Pain in calves when walking	☐	
Tingling or numbness	☐	
Muscle weakness	☐	
Pain / Burning in feet or hands	☐	
Foot ulcers	☐	
Joint pain	☐	
Swelling in feet or legs	☐	
MALE:		
Problems with erections	☐	
FEMALE:		
Vaginal discharge or itching	☐	
Breast lump	☐	
Breast discharge	☐	
Change in menstrual cycles	☐	
Currently taking calcium supplements	☐	