Your first appointment

When you come for your first appointment, please bring the following documents:

- Completed Patient Registration Form
- Completed Health Questionnaire
- Completed Authorization For Release of Information (if applicable or if you have a personal representative (spouse) who you are authorizing us to communicate with regarding your care.)
- Your current insurance identification card
- Your drivers license or another government issued ID

Directions to Columbus Endocrine Consultants

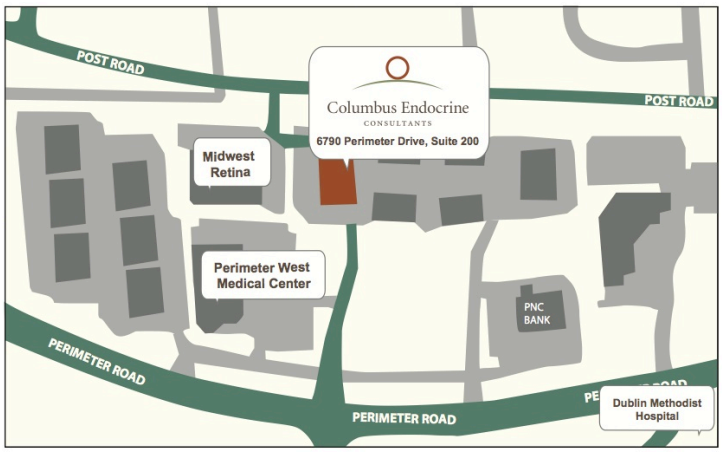
Please refer to the map provided to understand the immediate surroundings of Columbus Endocrine Consultants.

Directions from I270

- From I 270 take exit 17 B to merge onto OH-161W/US 33 W towards Marysville.
- Take exit to Avery-Muirfield Drive, and turn right
- Turn left at Perimeter Drive (second light from exit)
- Turn right at the sign for Perimeter West Medical Center
- Arrive at 6790 Perimeter Drive, Dublin.

Directions from US 33 E

- Drive on US 33 E towards Columbus
- Take exit to post road and turn left after the taking the exit onto post road
- Turn right at the sign on post road for Midwest Retina
- Arrive at 6790 Perimeter Drive, Dublin, on your left.



American Health Network of Indiana, LLC

PATIENT INFORMATION

NAME (Last, First Middle)			MRN	SSN#	BIRTHDATE	LANGUAGE	SEX
LOCAL ADDRESS	CITY, STATE ZIP		REFERRING PHYSICIAN		SECONDARY/BILLING ADDRESS		ETHNICITY
HOME PHONE	DAY PHONE	EMAIL ADDRESS	PRIMARY CARE PROVIDER		CITY, STATE ZIP		RACE
MARITAL STATUS	STUDENT STATUS ☐Full-Time ☐Part-Time	SMOKER (Y/N)?	VETERAN (Y/N)?	EMERGENCY CONTACT NAME		CONTACT PHONE	HOME PHONE

PRIMARY EMPLOYER	SECONDARY EMPLOYER (if Applicable)
ADDRESS	ADDRESS
CITY, STATE ZIP	CITY, STATE ZIP
WORK PHONE	WORK PHONE

RESPONSIBLE PARTY INFORMATION (if Different than above)

NAME (Last, First Middle)			SSN#	BIRTHDATE	LANGUAGE	SEX
LOCAL ADDRESS	CITY, STATE ZIP			SECONDARY/BILLING ADDRESS (if Applicable)		
HOME PHONE	DAY PHONE	EMAIL ADDRESS		CITY, STATE ZIP		
MARITAL STATUS	STUDENT STATUS ☐Full-time ☐Part-time	SMOKER (Y/N)?	VETERAN (Y/N)?	PRIMARY CARE PROVIDER	HOME PHONE	
RELATIONSHIP TO PATIENT						

PRIMARY INSURANCE

NAME OF INSURANCE COMPANY		POLICY#	
NAME OF INSURED		GROUP#	
ADDRESS OF INSURANCE COMPANY		COPAY AMT $	
CITY, STATE ZIP	PHONE	DEDUCTIBLE $	
RELATIONSHIP TO PATIENT		EFFECTIVE DATE	EXPIRATION DATE

SECONDARY INSURANCE (if Applicable)

NAME OF INSURANCE COMPANY		POLICY#	
NAME OF INSURED		GROUP#	
ADDRESS OF INSURANCE COMPANY		COPAY AMT $	
CITY, STATE ZIP	PHONE	DEDUCTIBLE $	
RELATIONSHIP TO PATIENT		EFFECTIVE DATE	EXPIRATION DATE

I understand that AHN will use my address/phone # listed above to leave messages regarding: the availability of test results, appointment reminders, etc., unless I request that the following alternative contact information be used: (e.g. work #, cell # of family member/friend)

_____

I request/authorize AHN to furnish the medical care necessary for my condition and understand that no guarantees as to the results have been made to me. I acknowledge I was offered a copy of the AHN Privacy Notice and Patient Financial Policies (including the Medicare agreement if applicable). I agree to abide by the terms of the Financial Policies, Terms, and Conditions.

_____ _____

SIGNATURE OF PATIENT/GUARDIAN DATE

4/15/2013

PATIENT HEALTH QUESTIONNAIRE

Patient Name _____ Date of Birth _____
Referring Physician _____

REVIEW OF SYSTEMS

Please circle if you have any of the following –

- environmental allergies, food allergies
- chest pain, leg pain with walking (claudication), palpitations/irregular heart beat
- fatigue, fever, night sweats
- cold intolerance, heat intolerance, excessive hunger, excessive thirst
- ear drainage, nasal drainage, hearing loss
- eye discharge, vision loss
- abdominal pain, constipation, diarrhea, vomiting
- menstrual cramps, pain with urination, blood in urine, heavy periods, excessive urination, vaginal discharge
- bleeding, easy bruising
- itching and rash
- bone/joint pain or swelling, weakness
- anxiety, depression
- cough, shortness of breath, wheezing

Your eye doctor (Ophthalmologist) _____
Your foot doctor (Podiatrist) _____

PATIENT MEDICATIONS

MEDICATION NAME (Example: Aspirin)	DOSE STRENGTH (81mg)	DOSE FREQUENCY (1 Tab once daily)

PATIENT MEDICAL HISTORY

(For surgical history below list the year as well if possible)

- ☐ Allergies
- ☐ Anemia
- ☐ Angina
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial fibrillation
- ☐ Benign prostatic hypertrophy
- ☐ Blood clots
- ☐ Cancer
- ☐ Cerebrovascular accident
- ☐ COPD
- ☐ Coronary artery disease
- ☐ Crohn's disease
- ☐ Depression
- ☐ Diabetes
- ☐ Gallbladder disease
- ☐ GERD
- ☐ Hepatitis C
- ☐ Hyperlipidemia
- ☐ Hypertension
- ☐ Irritable bowel disease
- ☐ Liver disease
- ☐ Migraine headaches
- ☐ Myocardial infarction
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Peptic ulcer disease
- ☐ Renal disease
- ☐ Seizure disorder
- ☐ Thyroid disease

Past Surgical History

- ☐ Angioplasty
- ☐ Angio w/ stent
- ☐ Appendectomy
- ☐ Arthroscopy knee
- ☐ Back surgery
- ☐ CABG
- ☐ Carpal tunnel release
- ☐ Cataract extraction
- ☐ Cholecystectomy
- ☐ Colectomy
- ☐ Colostomy
- ☐ Gastric bypass
- ☐ Hernia repair
- ☐ Hip replacement
- ☐ Knee replacement
- ☐ LASIK
- ☐ Liver biopsy
- ☐ ORIF
- ☐ Pacemaker
- ☐ Small bowel resection
- ☐ Thyroidectomy
- ☐ Tonsillectomy

Gender Specific

- ☐ Augmentation mammoplasty
- ☐ Bilat. tubal ligation
- ☐ Breast biopsy
- ☐ Cesarean section
- ☐ D and C
- ☐ Hysterectomy
- ☐ Mastectomy
- ☐ Myomectomy
- ☐ Reduction mammoplasty
- ☐ TAH / BSO
- ☐ Vaginal hysterectomy

Any additional history _____

FAMILY HISTORY

Indicate if your family members have any of the following –

DIAGNOSIS	CHECK IF YES	WHICH FAMILY MEMBER(S) HAVE IT?
Diabetes		
High Blood Pressure		
Cholesterol Problems		
Heart Disease		
Kidney Failure		
Overactive Thyroid		
Underactive Thyroid		
Thyroid Cancer		
Breast Cancer		
Prostate Cancer		
Osteoporosis		
Stroke		

MEDICATION ALLERGIES

MEDICATION	ALLERGIC REACTION

SOCIAL HISTORY

Marital Status _____
Number of children with ages _____
Occupation (If retired list previous occupation)_____
Tobacco: ☐Cigarette ☐Cigar ☐Chewing tobacco ☐Other (Specify) _____
Quantity per day _____Years Used _____Year Quit _____
Alcohol: Type (Example: Beer, Wine)_____
Quantity per week _____ Years Used _____ Year Quit _____
Recreational Drugs: Type _____ Years Used _____Year Quit _____
Exercise: Type _____ Amount per Week _____

PHARMACY

Name _____
Address _____
Phone number _____

FOR WOMEN ONLY

- How old were you when you had your first period? _____
- Are your cycles regular? ☐Yes ☐No
- When was your last period?_____
- When did you undergo menopause?_____
- How many pregnancies have you had?_____

Authorization For Use & Disclosure Of Protected Health Information

This authorization is required by the Health Insurance Portability and Accountability Act of 1996 to inform you of your rights to privacy with respect to your health care information. It authorizes the entity listed below to disclose your medical records to Columbus Endocrine Consultants (CEC).

Patient Name: _____ DOB: _____

Address: _____

_____

Information to be released (eg. History, Labs, Imaging, etc.): _____

_____

Release from the following entity(ies):

Name: _____

Phone: _____Fax: _____

Address: _____

_____

I understand that under the privacy rules, I have the right to revoke this authorization at any time in writing, except to the extent that action based on this authorization has been taken. This authorization will expire automatically 60 days from the date on which it is signed. If I choose to revoke this authorization sooner I must do so in writing to:

Columbus Endocrine Consultants
6790 Perimeter Drive, Suite 200
Dublin, OH 43016

I understand that by disclosing these records to CEC the practice will not re-disclose or use the records in a way that violates the privacy rules.

Patient/Guardian Signature _____Printed Name_____
Relationship to patient (if guardian) _____
Date _____