# Diabetes and Endocrine Associates

DIPLOMATES INTERNAL MEDICINE AND ENDOCRINOLOGY


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(760) 337-8803
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LAST NAME: _____ FIRST NAME: _____

STREET ADDRESS: _____ CITY: _____

STATE: _____ ZIP: _____ SEX :M_____ F_____ SSN: _____

DATE OF BIRTH: _____/_____/_____ MARITAL STATUS: S___M___D___W___

HOME #(  ) _____ CELL #(  ) _____ WORK#(  ) _____

WHO REFFERED YOU: _____

PRIMARY CARE PHYSICIAN: _____

NAME/PHONE NUM OF NEAREST RELATIVE: _____

DO WE HAVE PERMISSION TO LEAVE ANY RESULTS ON ANSWERING MACHINE? _____

ANY RESTRICTIONS? _____

IT IS OPTIONAL TO GET RESULTS BY E-MAIL, IF THAT IS YOUR PREFERENCE PLEASE DISCLOSE

E-MAIL ADDRESS: _____

***INSURANCE INFORMATION***

NAME OF INSURANCE: _____

SECONDARY, IF ANY? _____

NAME AND SOCIAL OF PRIMARY SUBSCRIBER OF INSURANCE, IF NOT YOURSELF:

I HEARBY AUTHORIZE MY INSURANCE TO PAY DIRECTLY TO DIABETES AND ENDOCRINE ASSOCIATES, BENEFITS DUE ME OUT OF INDEMNITY UNDER THE TERMS OF MY POLICY ISSUED BY THE INSURANCE COMPANY. PAYMENT IS DUE UPON RECEIPT OF AN ITEMIZED STATEMENT FOR SERVICES RENDERED. PAYMENT OF THIS AMOUNT HEREIN DIRECTED, IN WHOLE, IN PART, SHALL BE CONSIDERED THE SAME AS IF PAID TO ME DIRECTLY BY YOUR COMPANY.

LEGAL SIGNATURE: _____ DATE: _____

LIST ANY ALLERGIES & SENSITIVITIES/TYPES OF REACTION TO MEDICATIONS:

## DIABETES & ENDOCRINE ASSOCIATES MEDICAL GROUP, INC.

## CONSENT OF DISCLOSURE

**PATIENT**_____

**PHYSICIAN**_ RAYMOND I. FINK, M.D.

In connection with the medical services that I am receiving from the above named physician or physician, I hereby authorize the above named physician and/or group to disclose any and all information concerning my medical condition and treatment, including copies of applicable hospital and medical records to:

A. Any third party payer covering the medical services of the patient;

B. Other health care professionals and institutions involved in the delivery of health care to the patient;

C. The proponent of any legally sufficient subpoena, or in response to a court order;

D. Employees and agents of the practice, to the degree necessary to facilitate the provision of health care services and payment for such services;

E. Pharmacies;

F. Employees and agents of the research division, to the degree necessary to identify and determine eligibility for clinical research trials; and

G. Other parties as otherwise required by law.

In each case the practice shall take reasonable steps to ensure that only the minimum necessary information is disclosed in accordance with the above. I further understand that I have been given access to the physician's privacy notice and that I have had the opportunity to place special restrictions upon the consent hereby given.

Special Restrictions:_____

_____

This consent is valid from the date executed until revoked in writing by the patient.

Signed:_____

Date:_____

Witness:_____

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CONSET OF DISCLOSURE

PATIENT_____

PHYSICIAN_____RAYMOND I. FINK, M.D._____

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Signed:_____

Date:_____

Witness:_____

# AUTHORIZATION FOR RECORDS RELEASE

TO_____

ADDRESS_____

I hereby authorize and direct you to release to:

**DIABETES & ENDOCRINE ASSOCIATES**
**RAYMOND I. FINK, M.D.**
8851 Center Drive, Suite 404
La Mesa, California 91942
Telephone: (619) 463-1293 FAX: (619) 463-8230

The complete medical records in your possession relative to my illness and/or treatment during the period from _____ to _____

NAME_____ DATE_____

ADDRESS_____

SIGNATURE_____ WITNESS _____
(IF RELATIVE, STATE RELATIONSHIP)

# Diabetes and Endocrine Associates Financial Policy

**Thank you for your attention to this. Please let us know if you have any questions.**

**1. Co-Payments:** Co-payments are due at the time of check-in for your appointment. Our office accepts cash, personal checks, and credit cards.

**2. Missed Appointments:** If you have to reschedule your appointment, we need you to call us at least 24 hours before your appointment time so that we can schedule another patient from the waiting list. When you reschedule, please be sure to note the new time and date.

**3. Insurance Cards:** Your insurance card and complete insurance information is required at the time of each and every visit because these things change so often. If that is not possible, to avoid problems in billing, please provide us this information within 24 hours of your appointment. This information needs constant updating, and failure to do so is responsible for many misunderstandings.

**4. Insurance Policies:**

**Contracted and in-network:** As a courtesy, we will bill your primary and secondary insurance policies. However, you are ultimately responsible for payment of services not covered by your insurance plan. It is your responsibility to call and check with your insurance as to which services are covered.

**Non-contracted insurance companies and out-of-network:** If we are not contracted with your insurance company or have out-of-network benefits, payment is still due in full at the time of service. We will provide you with a copy of your completed charge ticket so that you may file with your own insurance company directly. This change in policy is due to the confusion that has occasionally occurred when CHMB has filed claims for individuals.

By signing below, you agree that you understand and will abide by the above described financial policy. Thank you again.

_____ _____ _____

Print Name Signature

Date

REVISED 4/1/12

**Raymond Fink MD- Diabetes and Endocrine Associates**
**DIABETES HEALTH**
**QUESTIONNAIRE**

Date:_____ Referring Physician:_____
Patient:_____
(Last Name) (First Name) (Middle Initial)
Date of Birth:_____ Sex: ___M ___F
What is the reason for your visit today?

_____
Date of diabetes diagnosis:_____
Type of Diabetes: ___Type 1 ___Type 2 ___Gestional ___Pre-diabetes ___Do not know
Check the symptoms you had at the time of diagnosis:
___Excessive thirst ___Excessive urination ___Weight loss ___Diabetic ketoacidosis
___Sever illness/hospitalization ___Other

How your diabetes was treated initially? ___Insulin ___Pills
Do you currently take insulin or any other injectable diabetes medications? ___Yes
___No
If yes, what kind, how much, and how often?_____
Do you take pills for diabetes? ___Yes ___No
If yes, what kind, how much, and how often?_____
Do you test your blood sugar at home? ___Yes ___No
If yes, how often?_____
Do you keep a diary of your blood sugar? ___Yes ___No
If yes, what is you meter? _____
What is your blood sugar range? _____
Do you experience low blood sugar reactions? ___Yes ___No
If yes, how many times per week? _____
Have you ever had a severe low blood sugar reaction that had to be treated by someone else or
that resulted in the paramedics being called? ___Yes ___No
If yes, when?_____
Do you have warning symptoms of low blood sugar? ___Yes ___No
Do have low blood sugar reaction at night? ___Yes ___No
Do you have a glucagon kit at home? ___Yes ___No
Do you test your blood sugar before you drive? ___Yes ___No
Do you test your blood sugar before you exercise? ___Yes ___No
How do you treat your low blood sugars?

_____

Do you follow a meal plan? ___Yes ___No
If yes, what kind?_____
Do you skip meals? ___Yes ___No
If yes, how often?_____
Do you snack between meals? ___Yes ___No
How often do you eat away from home?_____
Have you ever seen a nutritionist? ___Yes ___No

If yes, when and where?_____
Have you lost or gained weight recently? ___Yes ___No
If yes, how much? _____
Have you ever seen a diabetes educator? ___Yes ___No
If yes, when and where?_____
Do you exercise? ___Yes ___No
If yes, what kind of activity and how often?_____
Do you know what you A1C is? ___Yes ___No
If yes, when was it done?_____
Do you smoke tobacco? ___Yes ___No
If yes, how much?_____
Do you take aspirin? ___Yes ___No
If yes, how much and how often?_____
Do you drink alcohol? ___Yes ___No
If yes, how much and how often?_____
Do you suffer from any complications of diabetes? ___Yes ___No
If yes, what kind?_____
Do you see your eye doctor regularly? ___Yes ___No
Who is your eye doctor and when was your last eye exam?

_____
Do you see a foot doctor? ___Yes ___No
If yes, when was your last foot exam? _____
Do have a heart doctor? ___Yes ___No
If yes, when was your last visit? _____

Do you have any of the following conditions?
**___Heart disease ___History of heart attack, stent or pacemaker placement?**
**___Congestive heart failure? ___High blood pressure ___High cholesterol ___Thyroid condition**
**___Gastrointestinal problem ___Kidney disease ___Nerve damage ___Sexual dysfunction**
**___Pain or numbness in your feet? ___Depression? ___Cancer ___Other**

Please provide more information if you checked any of the conditions above:_____
_____
_____
_____
What other medical conditions are you currently being treated for?_____
_____
_____
Please list any hospitalizations or surgeries you may have had in the past:_____
_____
_____

Please list all of your medications, including the amount and how often you are taking it:_____

Please list all of your food and drug allergies:_____

Is there anyone in your family with diabetes? __**Yes** __**No**
If yes, who?_____
Are there any other medical condition in your family? __**Yes** __**No**
If yes, describe them:_____

*Please use the back of this form to discuss any other issues or problems you would like to share*

***THANK YOU!***

Patient Signature:_____ Date:_____

Physician Signature:_____ Date:_____