7200 South Alton Way # A-120 Centennial, CO 80112 P: (720) 282-2288; Fax: (720) 282-2048

PATIENT NAME: (Last, first): _____

HOME ADDRESS _____
Street City State and Zip Code

GENERAL

HOME PHONE (_____)_____CELL PHONE (_____)_____DOB: _____

SEX: M / F RACE:_____ MARITAL STATUS S M D W O (CIRCLE ONE)

EMPLOYED: FULL PART TIME RETIRED OTHER (CIRCLE ONE) STUDENT: FULL PART TIME N/A (CIRCLE ONE)

EMAIL: (REQUIRED IF YOU HAVE ONE): _____

EMPLOYER OR SCHOOL _____

NAME OF SPOUSE/PARTNER (PARENT FOR UNDER 21): _____

ADDRESS _____

HOME PHONE (___)_____ CELL PHONE (__)_____

REFERRING PROVIDER (NAME):_____

PRIMARY CARE PROVIDER:(will receive reports unless otherwise specified):_____

IN CASE OF EMERGENCY NEAREST RELATIVE / FRIEND NOT RESIDING AT THE SAME RESIDENCE AS YOURS:

NAME_____PHONE (___)_____

INSURANCE

PRIMARY INSURANCE COMPANY _____
Insured Name_____**Social Security #** _____

SECONDARY INSURANCE COMPANY _____
Insured Name_____**Social Security #** _____

FINANCIAL

I HEREBY AUTHORIZE MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO THE NAMES PROVIDED FOR PROFESSIONAL SERVICES RENDERED. I ALSO AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS ANY CLAIM FOR SERVICES RENDERED. I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL .

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES FOR SERVICES RENDERED TO ME, OR MY DEPENDENT, INCLUDING THE BALANCE REMAINING AFTER PAYMENT OF POSSIBLE INSURANCE BENEFITS.

SIGNED _____DATE _____(PATIENT, OR GUARDIAN IF MINOR)

Name:_____ Date of Birth:_____

Patient Medical History Form

YES / Year Diagnosed	NO		YES/ Year Diagnosed	NO	
		Heart Attack			Kidney Disease
		Irregular Heart Beat			Bladder Infections
		Heart Operation			Kidney Stones
		Angioplasty / Stents			Depression
		High Blood Pressure			Anxiety
		Stroke / TIA			Eating Disorder
		Asthma			Reflux / Heartburn
		Emphysema *or* COPD			Hepatitis
		Head Operations			Other Liver Problems
		Cancer (If Yes, What Kind?)			Arthritis (If YES, Which Joints?)
		Brain Tumor			
		Headaches (if yes what type?) Migraine/ Sinus/ Tension			Bleeding Disorders
					Blood Clots in Lungs or Legs
		Autoimmune diseases			Elevated Cholesterol
		Osteoporosis / Osteopenia			Diabetes
		Polycystic Ovarian Syndrome (PCOS) / Metabolic Syndrome			Colitis / Crohn's / Celiac Disease
		Thyroid Disease			Seizures
		Calcium / Parathyroid Disease			Radiation Head / Neck
		Hysterectomy /Ovaries removed (yes or no ?)			Low Testosterone
		Cataracts			Glaucoma
		Sleep Apnea			Falls
		Low Growth Hormone			Acromegaly
		Adrenal Insufficiency			Cushing's
		Broken Bones			Recent CT scan or MRI

Last Menstrual Period: _____ Number Pregnancies_____ #Miscarriages_____

SURGICAL HISTORY :

Other Medical History not noted above? If yes, list below or on separate page:

Name:_____ Date of Birth:_____

Social History:

Marital Status: Single ○ Married ○ Divorced ○ Other ○

Do you have children? Yes ○ no ○ How many?_____

Education Completed:

o High School o Some College o College Degree o Graduate Degree o Other

Do you work outside the home? o Yes o No Occupation: _____

If no, what was your prior occupation?_____

Do you exercise regularly? o Yes o No

If Yes, _____minutes &_____times a week

Do you smoke (include cigarettes, cigars, ecigs, vaping)? o Yes o No

If Yes, How many per day:_____
How many years?_____

If no, did you ever smoke? o Yes o No When did you quit?_____

How much did you previously smoke? _____packs per day _____years

Do you drink alcohol? o Yes o No How many drinks each day? _____

Do you use illegal drugs? o Yes o No Which ones?_____

Do you use marijuana? o Yes o No Smoke, edible, topical?_____

Name:_____ Date of Birth:_____

FAMILY HISTORY (do not include spouse or your own medical history):

****Check appropriate box. If YES, indicate which family members (not yourself)****

Medical Problem	Yes	No	WHICH FAMILY MEMBER (S)? Indicate maternal/paternal
Heart Attacks- If *yes* , age of first one?			
Strokes			
Diabetes -If *yes*, kidneys affected?			
Thyroid Disease; If *yes*, under or overactive			
Pituitary / Adrenal			
Colitis / Crohn's / Celiac			
Lupus / RA / Autoimmune Disorders			
Kidney Stone / High Calcium			
Asthma / Emphysema / COPD			
Osteoporosis -If yes, any fractures?			
Cancer- If *yes*, what kind?			
High Cholesterol / Triglycerides			
High Blood Pressure			
Clots in Lungs / Legs			
Other Conditions			

Name:_____ Date of Birth:_____

Review of Systems

No findings	Please circle symptoms you are having **right now**
	Constitutional: wt. gain or loss, fatigue, heat or cold intolerance
	Eyes: double vision, prominent eyes, eye irritation, blurred vision
	ENT: headaches, neck pain, hoarseness, swallowing problems, sore throat
	Lungs: shortness of breath at rest or exertion, cough, wheezing
	Cardiac: chest pain, palpitations, swelling of legs or feet
	GI: constipation, diarrhea, abdominal pain, nausea, vomiting, heartburn
	Musculoskeletal: joint pain, muscle cramps, stiffness
	GU: urinary frequency, urination at night, blood in urine, discharge
	Gyn: no periods, irregular periods, heavy or painful periods
	Skin: rashes, thinning hair, brittle nails, new or changing skin growths
	Neuro: tremor, numbness, tingling, muscle weakness
	Heme/Lymph: bleeding problems, bruising, swollen glands
	Psychiatric: depression, anxiety, sleep disorders, substance dependence
	Allergy: eczema, seasonal allergies, hives

Allergies to Medications and Significant Drug Reactions:

_____

_____

_____

_____

_____

_____

Food allergies:_____

Name:_____ Date of Birth:_____

PATIENT MEDICATION/DOSE LIST

MEDICATION NAME	STRENGTH	HOW OFTEN TAKEN

Medication Reconciliation

I give the office permission to reconcile my medications through my insurance prescription records to ensure accuracy and avoid drug interactions.

Initial:_____

LOCAL PHARMACY NAME AND ADDRESS:

_____

_____

_____

_____

LOCAL PHARMACY PHONE AND FAX:

_____

_____

MAIL ORDER PHARMACY NAME, ADDRESS, PHONE AND FAX:

_____

_____

_____

_____

_____

Which pharmacy is Preferred?_____

Name:_____ Date of Birth:_____

HIPAA INFORMATION AND CONSENT FORM

By my signature below, I state that I have received a copy of this Form, and do hereby consent to the terms of the HIPAA INFORMATION AND CONSENT FORM

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April14, 2003. Many of the policies have been our practice for years. This form is a "friendly" version. A more complete text is posted in the office and is available in printed form.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov.

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding with identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.
2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, email, text messaging, U.S. mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.
3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI, but must agree to abide by the confidentiality rules of HIPAA.
4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.
5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.
6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods, or services.
7. We agree to provide patients with access to their records in accordance with state and federal laws.
8. We may change, add, delete or modify any of these provisions to better serve the needs of both the practice and the patient.
9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I_____, _____do hereby acknowledge that I have received the Diabetes and Endocrinology of Denver HIPAA Information and Consent Form.

Name:_____ Date of Birth:_____

Signature: _____ Date: _____

Diabetes & Endocrinology of DENVER

AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

Patient Name: _____ Previous Name:_____

Birthdate:_____ Phone: _____Address:_____

City:_____ State:_____ Zip: _____

I AUTHORIZE:

(Name of Health Facility, Individual, Agency, ETC)_____

(Address)_____

(City, State, & Zip)_____

TO RELEASE TO:

Diabetes and Endocrinology of Denver
7200 S. Alton Way, Suite A120
Centennial, CO 80112
(720) 282-2048 (office fax)

INFORMATION TO RELEASE:

o Pathology Reports o Laboratory Results
o Radiology/Imaging Results . reports only. Do not send discs
o Other _____
Please do not send office visit notes unless specifically requested

The foregoing records are released for Dr. A Jonathon Weinstein at Diabetes and Endocrinology of Denver.

Date: _____ Patient or Guardian Printed Name:_____

Name:_____ Date of Birth:_____

Patient or Guardian Signature_____

ADDITIONAL PROVIDER CONTACT INFORMATION

We feel it is very important to keep your other health care providers informed about the care that you receive at Diabetes and Endocrinology of Denver. If there are any providers that you would like us to forward your office visit notes, labs, procedures, etc… to please list them below:

Provider Name:_____ Specialty:_____
Address:_____ City:_____ State:____ Zip:_____

Phone Number:_____ Fax Number:_____

Provider Name:_____ Specialty:_____
Address:_____ City:_____ State:____ Zip:_____

Phone Number:_____ Fax Number:_____

Provider Name:_____ Specialty:_____
Address:_____City:_____State:____ Zip:_____

Phone Number:_____ Fax Number:_____

Provider Name:_____ Specialty:_____
Address:_____ City:_____ State:____ Zip:_____

Phone Number:_____ _____Fax Number:_____

Provider Name:_____ Specialty:_____
Address:_____ City:_____ State:____ Zip:_____

Phone Number:_____ Fax Number:_____

Patient Name:_____ Date:_____

Patient (or Guardian) Signature_____

Name:_____ Date of Birth:_____

Preferences for Contact & Release of Information Regarding Test Results

We feel it is very important to keep you informed and educated about your test results and other health information as we work as your partners in your care. However, we also strive to protect the privacy of your health information.
Please indicate how you would like to be contacted by our physicians and staff. We will follow the guidelines you set forth here, unless otherwise advised.
Please be sure to update this information as needed, for phone number changes or changes in preferences.

HOME PHONE NUMBER: _____

o Use this number first

o Ok to leave a detailed message or

o Leave call-back number only

CELL PHONE NUMBER: _____

o Use this number first

o Ok to leave a detailed message

o Leave call-back number only

WORK PHONE NUMBER :

o Use this number first

o Ok to leave a detailed message

o Leave call-back number only

If you would like us to waive your protected rights and provide messages, information, or results to a spouse, significant other, or family member, please indicate below. My protected health information may be shared with the following persons:

Name:_____ Relationship:_____
Name:_____ Relationship:_____
Name:_____ Relationship:_____

Patient Name: _____Date:_____

Patient (or Guardian) Signature:_____

Diabetes & Endocrinology of DENVER

Credit Card Policy

To help us serve our patients best, it is our policy to keep a credit card number on file. This information is held off site with the credit card billing company and is subject to the same protections as any other credit card transaction. *None of the office staff have access to this information after it has been entered into your account.*

Because of the high demand for our specialties, we require a credit card to hold a new patient appointment. You may enter all your information in the patient portal in advance if you choose to, but you will need to call the office at least 48 hours prior to your appointment to collect the credit card information.

If you are existing patient who has not been seen in this office since our opening, please have credit card information ready when calling to schedule your first follow up.

Just as when you give your credit card number when reserving a hotel or rental car, this card will **never** be charged without your express consent **except** in the following situations:

- You have an unexcused late cancel or no show, in which case the late cancel/no show fee will be charged as described in the office policies, OR
- You have an outstanding balance that is more than 90 days past due.

Name:_____ DOB:_____

Acknowledgement of Office Policies

Insurance Information

Diabetes and Endocrinology of Denver participates with many insurance companies. Your insurance may require a referral from your primary care physician. It is your responsibility to know in advance if a referral is needed. If your insurance requires a referral and one is not in place and you are seen, you will be responsible for your visit. Please check with your carrier in advance regarding referrals and deductibles.

Cancellation/No Show/Late Arrival

If you cancel an appointment with less than one business day notice or no show for your appointment, you will be charged $50 for a follow up visit and $100 for a new patient visit. If you arrive more than 10 minutes late for your appointment, you may be asked to reschedule and a no show fee may be charged. We ask that you arrive 10 minutes prior to your appointment time for a follow up visit, and 20 minutes prior to your appointment time for a new patient visit. Parking can be an issue at Sky Ridge so please plan appropriately.

Phone Hours

8:30 a.m to 4:30 p.m. Monday through Friday

Prescription Refills

Please contact your pharmacy first for refills on any existing prescriptions written by Dr. Weinstein. Please allow 3-5 business days for refills and be sure to call your pharmacy first to see if a refill was sent prior to contacting the office. Portal messages are the most effective way to contact the office if the pharmacy doesn't have the refill. *You should request refills when you have 7-10 days of medication remaining to ensure you don't run out*. If requesting refills through the portal, please specify all medications that need refills, whether you need a 30 day or 90 day prescription and to which pharmacy refills should be sent. Please include all medications in one message. Do not send separate messages for each medication. *If you are overdue for a follow up appointment, refills may be denied until you are seen and/or scheduled.*

Patient Portal Messages

This is the preferred and most efficient way to communicate with the office and your provider for all non-urgent questions and refill requests. Please allow 3-5 business days for a response. If you have an urgent matter that cannot wait 3-5 business days, please send a portal message AND call the office. Please use "urgent" in the subject line of any urgent portal messages. Please include all questions in the same message. Do not send duplicate messages as it delays response times. Please do not add on to old messages, instead create a new message for a new issue.

Phone Messages

Non-urgent phone messages for your provider will be returned within 5-7 business days unless we are notified of urgency. If you have an urgent matter and don't receive a prompt callback, please call the office again. Portal messaging is not only preferred, but faster.

Disability and SSI

Dr. Weinstein doesn't complete any disability or SSI paperwork. This needs to be taken to your primary care provider.

Late Payment Fees

A $30 late payment fee will be added to any bill not paid 90 days after the date of service, unless you have contacted the office and made mutually agreed upon payment arrangements. You should not wait until your next appointment to pay balances.

Unfortunately, failure to pay bills in a timely fashion may result in discharge from the practice and/or having your account sent to collections.

I have received and reviewed the office policies.

Print name: _____

Signature: _____