Diabetes & Endocrinology Associates of Stark County, Inc.
4565 Dressler Road NW, Ste 111
Canton, OH 44718
Telephone (330) 493-0013 Fax (330) 493-6973

Dear New Patient:

We would like to take this opportunity to welcome you to our practice. We are committed to providing you with the best care we can. While we strive to provide our patients with excellent clinical results, we also work to make every patient feel supported and respected. Our goal is to make sure each patient is treated with kindness, respect, and professionalism.

To ensure the best patient experience, please do the following:

- Bring a copy of your most current insurance card for us to bill your insurance properly.
- Bring a list of your current medications and dosages.
- Bring a copy of your last blood work and any test results.

Our office is contracted with many insurance companies. All of the insurances vary in coverage and deductibles, so your responsibility will be handled according to your policy. You are responsible for contacting your primary doctor to obtain a referral, if needed. Many insurance companies require a pre-certification for certain procedures. You will be responsible for notifying staff if pre-certification is necessary for your insurance policy. Any co-payment is required at time of service.

We will do our best to refill medications in a timely manner, but our office requires a request for medication refill at least 2 business days before you run out of medication.

If you cannot keep an appointment, please call our office 48 hours in advance. If not, you will be charged a $50.00 cancellation fee.

If you have any questions regarding the above, please do not hesitate to ask for our assistance.

We look forward to seeing you in our office.

Sincerely,

Diabetes & Endocrinology Associates of Stark County, Inc.

DIABETES & ENDOCRINOLOGY ASSOCIATES OF STARK COUNTY, INC.

REFERRED BY: _____ DATE: _____

PATIENT NAME	SS#	SEX	MARITAL STATUS S M W D SEP	DATE OF BIRTH	AGE

HOME ADDRESS	CITY & STATE	ZIP CODE

HOME PHONE#	CELLULAR PHONE#	EMAIL ADDRESS

PATIENT'S EMPLOYER OR RETIRED FROM	OCCUPATION	ALT/EMERG PH#	RELATION TO PATIENT

EMPLOYER ADDRESS	CITY & STATE	ZIP CODE	HOW LONG EMPLOYED	BUSINESS PHONE#

SPOUSE OR PARENT NAME	SS#	SPOUSE'S DOB	HOME PHONE#

SPOUSE OR PARENT'S EMPLOYER	OCCUPATION	HOW LONG EMPLOYED	BUSINESS PHONE#

SPOUSE OR PARENT'S EMPLOYER ADDRESS	CITY & STATE	ZIP CODE

PLEASE HAVE YOUR INSURANCE CARDS AVAILABLE

PRIMARY INSURANCE COMPANY (FIRST COMPANY TO FILE)	ADDRESS	CITY & STATE	ZIP CODE

NAME OF INSURED	INSURED'S DOB	POLICY/IDENTIFICATION #	GROUP #

NAME OF 2ND INSURANCE (2ND COMPANY TO FILE)	ADDRESS	CITY & STATE	ZIP CODE

NAME OF INSURED	INSURED'S DOB	POLICY/IDENTIFICATION #	GROUP#

PLEASE READ: ALL CHARGES ARE DUE AT THE TIME OF SERVICE. IF HOSPITALIZATION IS INDICATED, THE PATIENT IS RESPONSIBLE FOR FURNISHING INSURANCE CLAIM FORMS AND PRE-ADMISSION CERTIFICATION INFORMATION PRIOR TO HOSPITALIZATION.

ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT. NECESSARY FORMS WILL BE COMPLETED TO HELP EXPEDITE INSURANCE CARRIER PAYMENTS. HOWEVER, THE PATIENT IS RESPONSIBLE FOR ALL FEES, REGARDLESS OF INSURANCE COVERAGE. IT IS ALSO CUSTOMARY TO PAY FOR SERVICES WHEN RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE WITH OUR ACCOUNTING DEPARTMENT.

INSURANCE AUTHORIZATION, ASSIGNMENT AND MEDICAL RELEASE

I request that payment of benefits be made on my behalf to **DIABETES & ENDOCRINOLOGY ASSOCIATES OF STARK COUNTY, INC.** for any services furnished me by their physicians. I authorize release to the Health Care Financing Administration, insurance carriers and/or medical facility any medical information about me needed to determine quality of care and/or payment for these related services. I understand that I am responsible for any amount not covered by insurance unless otherwise informed. This authorization is valid until I choose to revoke it in writing.

DATE: _____ SIGNATURE: _____

DATE: _____ SIGNATURE: _____

DATE: _____ SIGNATURE: _____

DATE: _____ SIGNATURE: _____

Diabetes & Endocrinology Associates of Stark County, Inc.

Name: _____

Date: _____

Surgical History

Yes	No	Surgeries	Comments
		Heart cath	
Other surgeries			

Social History

Yes	No	Tobacco/Alcohol/Drugs	Comments
		Smoking: past / current (please circle)	
		Alcohol use: rarely / occasionally / daily	
		Drug use	

Review of Systems

Please indicate if you have the problems during the last year.

Yes	No	General	Comments
		Fatigue	
		Recurrent fever	
		Night sweats	
		Weight change	
		Weight gain in the last year	
		Weight loss in the last year	
Yes	**No**	**Eyes**	**Comments**
		Wear glasses or contacts	
		Eye drainage	
		Injuries	
		Itching	
		Pain	

Yes	No	Eyes	Comments
		Spots before eyes	
		Blurred vision	
		Decreased peripheral vision	
		Double vision	
Yes	**No**	**Ears**	**Comments**
		Recent ear infection	
		Ear drainage	
		Hearing difficult	
		Ear pain	
		Ringing in ears	
Yes	**No**	**Nose**	**Comments**
		Sinus drainage	
		Nosebleeds	
		Obstructed breathing	
		Hay fever	
Yes	**No**	**Mouth & Throat**	**Comments**
		Bleeding gums	
		Dental problems	
		Hoarseness	
		Mouth sores	
		Difficulty swallowing	
		Sore throat	
		Sores or ulcers in mouth or tongue	
Yes	**No**	**Cardiovascular**	**Comments**
		History of blood clots	
		Chest heaviness	
		Chest pain	
		History of deep vein thrombosis	
		Heart attack	
		Heart murmur	
		High blood pressure	
		High cholesterol	
		Leg pain when walking	
		Palpitations	

Yes	No	Cardiovascular	Comments
		Rheumatic fever	
		Swelling of legs	
		Swelling of ankles	
		Varicose veins	
		Phlebitis	
Yes	**No**	**Respiratory**	**Comments**
		Asthma	
		Bronchitis	
		Chronic cough	
		History of pulmonary embolism	
		Pneumonia	
		Sleep apnea	
		Shortness of breath on exertion	
		Shortness of breath when lying flat	
		Production of sputum	
		Blood streaked sputum	
		History of tuberculosis	
Yes	**No**	**Gastrointestinal**	**Comments**
		Abdominal pain	
		Abdominal cramping	
		Rectal bleeding	
		Constipation	
		Diarrhea	
		Gallbladder problems	
		Hemorrhoids	
		Hepatitis	
		Liver problems	
		Nausea	
		Black stools	
		Stomach ulcers	
		Vomiting	
Yes	**No**	**Genitourinary**	**Comments**
		Bladder infection	
		Difficulty starting urine stream	

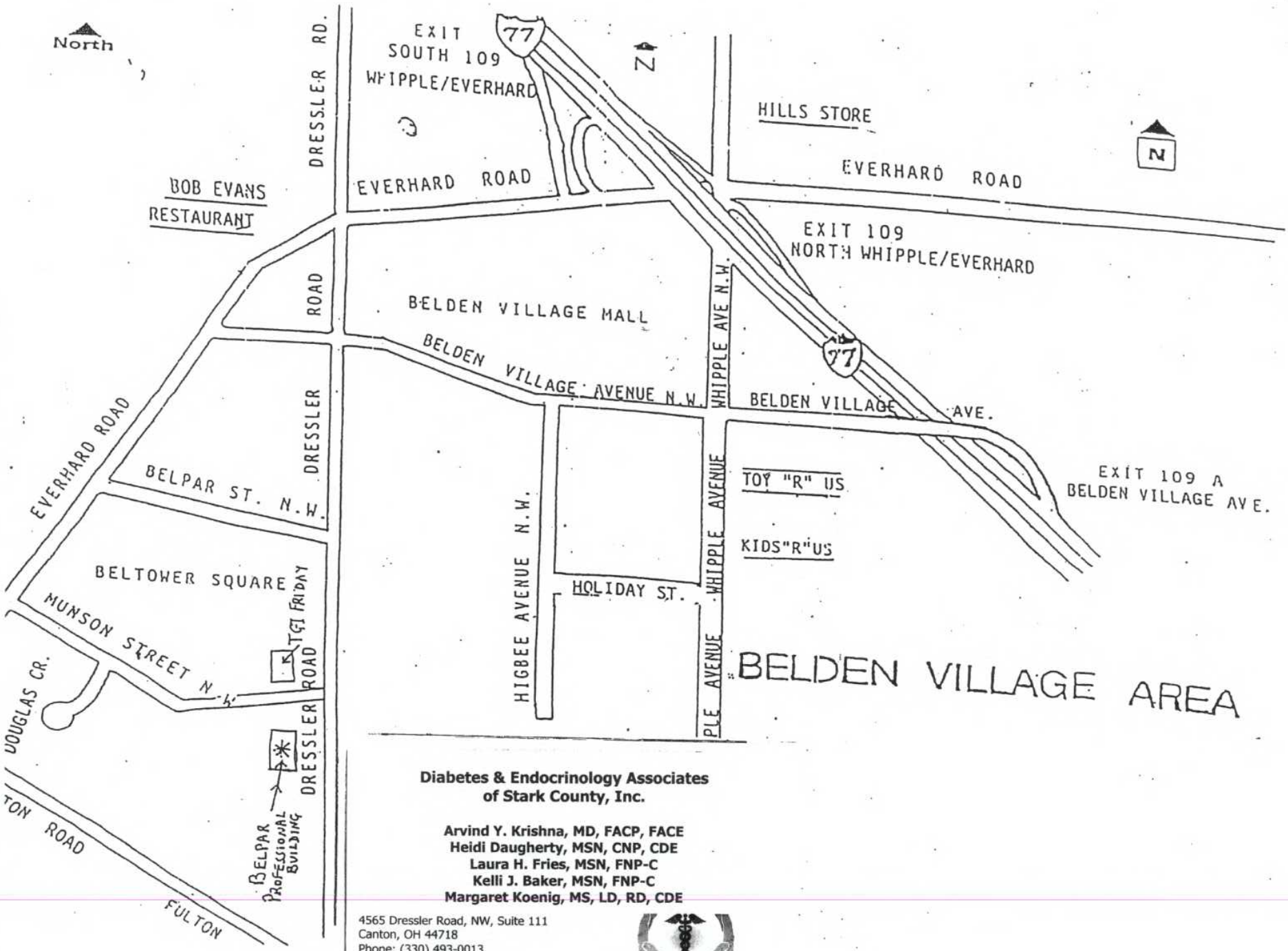
Yes	No	Genitourinary	Comments
		Difficulty stopping urine stream	
		Incontinence	
		Kidney infection	
		Kidney stones	
		Getting up to urinate at night	
		Burning with urination	
		Blood in urine	
Yes	**No**	**Musculoskeletal**	**Comments**
		Broken bones	
		Joint pain	
		Back pain	
		Spasm	
		Joint stiffness	
Yes	**No**	**Skin**	**Comments**
		Easy bruising	
		Dryness	
		Poor healing	
		Rash	
		Scaling	
		Skin sores	
		Ulcers	
		Abnormal hair growth	
Yes	**No**	**Neurological**	**Comments**
		Dizziness	
		Epilepsy	
		Headache	
		Head injuries	
		Loss of consciousness	
		Numbness	
		Paralysis	
		Seizures	
		Stroke	
		Vertigo	
		Weakness	

Yes	No	Endocrine	Comments
		Diabetes	
		Goiter	
		Hormone problems	
		Intolerance to cold	
		Intolerance to heat	
		Neck swelling	
		Excessive thirst	
		Thyroid problems	
		Excessive urination	
Yes	**No**	**Hematological**	**Comments**
		Anemia	
		Excessive bleeding	
		Mononucleosis	
Yes	**No**	**Gynecological**	**Comments**
		Age started menses	
		Irregular menses	
		First day of last menstrual cycle	
		Pregnancies	
		Deliveries	
		Miscarriages	
		Discharge	
		Spotting	
		Menopause	
		Breast lumps	
		Breast discharge or milk	
		Mammogram	

Additional pertinent information: _____

Medication lists:

Allergies:



Diabetes & Endocrinology Associates of Stark County, Inc.

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Dedication. Compassion. Excellence

NAME: _____ DATE: _____

DOB: _____ PH#: _____

PHARMACY: _____ PH#: _____

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