Mid Atlantic Diabetes and Endocrinology Associates, LLC

555 Iron Bridge Road, Suite 18
Freehold, NJ 07728
Tel: 732-409-6233
Fax: 732- 409-6414

PATIENT REGISTRATION SHEET

Please complete the ENTIRE form and sign where indicated.

Last Name:_____ First Name:_____ MI:_____

Address:_____

City:_____ State: _____ Zip:_____

Date of Birth: ___/___/___ Social Security #: ___-___-____ Marital Status: _____Sex: _____

Home #: (____) ___-_____ Work: (___) ___-_____ Cell #: (___) ___-_____

Email Address: _____

Primary Care Physician: _____ Phone: (___) ___-_____

Referring Physician: _____ Phone: (___) ___-_____

Emergency Contact Name: _____ Phone: (___) ___-_____

Name of Insurance Company: _____ Phone: (___) ___-_____

Address:_____

City:_____ State: _____ Zip:_____

Group #: _____ Policy #: _____

Secondary Insurance: _____ Phone: (___) ___-_____

Address:_____

City:_____ State: _____ Zip:_____

Group #: _____ Policy #: _____

Policy holder

Name: _____ Date of Birth: ___/___/___

Relationship to Patient: _____ Social Security #: ___-___-____

FOR STATISTICAL PURPOSES ONLY (please check the appropriate space)

Race: American Indian or Alaska Native___ Asian___ Black or African American ___

Native Hawaiian or Other Pacific Islander ___ White _____Other_____ Declined ___

Ethnicity: _____ Declined _____

RELEASE OF INFORMATION

I authorize the release of all information necessary to process my insurance claims and pertinent to my medical care. This release will remain in effect until revoked by me in writing. A photocopy of this release is to be considered as valid as the original.

Signature: _____ Date: ___/___/___

ASSIGNMENTS OF BENEFITS

I assign all medical and/or surgical benefits including major medical benefits to which I am entitled, including Medicare, Blue Shield, HMO plans and commercial insurance to Mid Atlantic Diabetes and Endocrinology Associates, LLC and its licensed providers. This assignment will remain in effect until revoked by me in writing. I hereby authorize the above to release information to secure payment on my behalf.
I understand that I am responsible for all charges. I have read this information and understand it.

Signature: _____ Date: ___/___/___

FOR MEDICARE PATIENTS

_____ _____ _____

Name of Beneficiary/ Member (Print name as it appears on your card) | Medicare Number | Patient ID Number

"I request that payment of authorized Medicare benefits be made on my behalf to Mid Atlantic Diabetes and Endocrinology Associates, LLC or any of the individual physician members for any services furnished to me by an of its individual providers. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Service and its agents any information needed to determine these benefits or the benefits payable for related services."

_____ _____

Medicare patient Signature | Date

"I request that payment of authorized Medigap benefits be made on my behalf to Mid Atlantic Diabetes and Endocrinology Associates, LLC or any of its individual physician members for any services furnished to me by any of its individual providers. I authorize any holder of medical information about me to release to my Medigap Insurer (named below) or its agents any information needed to determine these benefits or the benefits payable for related services."

_____ _____

Medicare Patient Signature | Date

Name of Medigap Insurance: _____Poilcy Number:_____ Person holding Medigap insurance_____

Patient History Form

Name: _____

Please indicate (circle) if you have any of the following:

Asthma	Heart disease	Arthritis
Bronchitis	High blood pressure	Depression
COPD	High cholesterol	Gallbladder disease
Emphysema	Abnormal heart valve	Hepatitis
Sarcoidosis	Artificial heart valve	Seizures
Other lung disease	Diabetes	Cancer
Other:_____	Hypothyroidism	
	Thyroid Nodule /s	

Please list any surgery that you have had, along with approximate dates:

_____

_____

_____

_____

Please list any pertinent family medical history:

Mother: Age__ or age of death if deceased:_____ history:_____

Father: Age__ or age of death if deceased:_____ history:_____

# of Brothers: _____**history:**_____

 # Sisters: _____**history:**_____

Others: _____

Medications:

Please list all medications (including non-prescription and over-the-counter items such as vitamins) that you take on a regular basis. Include the name, dose and frequency with which you take it.

Please list any allergies: None (circle)

Please provide us with the name, address and phone number of the pharmacy you generally use (if applicable). If you have an ID for a mail-away pharmacy, please write that also: _____

REQUEST FOR CONFIDENTIAL COMMUNICATIONS

Name of the Patient: _____
(Please print)

Date of Birth: _____

I request that all communications to me (by telephone, mail or otherwise) by Mid Atlantic Diabetes and Endocrinology Associates and/or his staff be handled in the following matter:

- For written communications: Address to: _____
  _____
  _____
  _____

- For oral communications: Call: _____
  (Phone number)

  May we leave a message?
  - ❑ Yes
  - ❑ No

If the address provided above is not your home address or is not a street address, please provide us with a street address for purposes of ensuring payment:

_____
_____
_____

_____
Patient Signature

_____
Date

For Practice Use Only:

Practice: Accepts _____ Denies _____
Privacy Officer Signature: _____
Date: _____

ACKNOWLEDGMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

_____ _____

Patient Name (please print) Date

_____

Parent or Authorized Representative (if applicable)

_____

Signature

Mid Atlantic
Diabetes and Endocrinology Associates

Melissa G. Young, MD FACE FACP
555 Iron Bridge Rd, Suite 18
Freehold, NJ 07728

Phone: 732-409-MADE (6233)
Fax: 732-409-6414
www.midatlendo.com

Practice Policy Receipt

I have received and reviewed the practice policies set by Mid Atlantic Diabetes and Endocrinology Associates, LLC with regards to: Telephone Calls, Prescription Requests, Cancellations and "No-Shows", and Late Arrivals, as well as its Financial Policies.

Signature

Printed Named

Date