ENDOCRINE ASSOCIATES OF THE QUAD CITIES, S.C.

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NAME: LAST_____FIRST_____MI_____

ADDRESS_____

CITY_____STATE_____ZIP_____

HOME PHONE #_____CELL #_____SS#_____

DATE OF BIRTH_____/_____/_____AGE_____ EMAIL ADDRESS_____

SEX: M or F MARITAL STATUS: SINGLE_____ MARRIED_____ DIVORCED_____ SEPARATED_____ WIDOWED_____

ETHNICITY: WHITE____ AFRICAN AMERICAN____ HISPANIC____ ASIAN____ OTHER_____

EMPLOYER_____WORK #_____

REFERRING DOCTOR/PROVDER_____**FAMILY DOCTOR/PROVIDER** _____

NAME OF SPOUSE_____SPOUSE'S D.O.B _____

SPOUSE'S SOCIAL SECURITY NUMBER (*IF POLICYHOLDER)*_____

PHARMACY NAME AND LOCATION_____

COMPLETE BELOW IF SOMEONE OTHER THAN PATIENT IS RESPONSIBLE FOR BILL:

NAME_____RELATIONSHIP TO PATIENT_____

ADDRESS_____PHONE #_____

SS #_____DATE OF BIRTH_____/_____/_____EMPLOYER_____

****ADVANCED DIRECTIVES – Do you have any of the following? If so, circle all that applies to you and provide the office with a copy for our records**.

Unknown None Do Not Resuscitate Living Will Durable Power of Attorney (POA) Health Care Proxy

PLEASE LIST THE PERSON OR PERSONS WHO WE MAY INFORM ABOUT YOUR GENERAL MEDICAL CONDITION, DIAGNOSIS, TREATMENT, PAYMENT AND/OR OTHER HEALTHCARE MATTERS. FOR EXAMPLE, IF YOUR SPOUSE HANDLES YOUR MEDICAL CARE, YOU WILL NEED TO LIST THEM BELOW. *IF THERE IS NO ONE YOU WANT TO GIVE CONSENT TO, SIMPLY WRITE 'NO ONE' THEN SIGN/DATE*. THIS AUTHORIZATION IS VALID UNLESS REVOKED IN WRITING BY YOU. **PLEASE NOTE – THIS DOES NOT INCLUDE RELEASE OF MEDICAL RECORDS WHICH REQUIRES A WRITTEN RELEASE FORM.**

NAME_____RELATIONSHIP_____PHONE_____

NAME_____RELATIONSHIP_____PHONE_____

NAME_____RELATIONSHIP_____PHONE_____

SIGNATURE_____DATE_____

INSURANCE AUTHORIZATION AND ASSIGNMENT

I hereby authorize Endocrine Associates to furnish information to insurance carriers concerning my illnesses and treatments. I hereby assign to the doctor all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by my insurance. (A photocopy of this authorization and assignment shall be considered as valid as the original.)

SIGNATURE_____DATE_____

PLEASE NOTE- *All professional services rendered are charged to the patient. Necessary forms will be completed to expedite insurance claims. The patient is responsible for fees, regardless of insurance coverage.* ***IT IS CUSTOMARY TO PAY FOR SERVICES WHEN RENDERED (INCLUDING COPAYS) UNLESS OTHER ARRANGEMENTS ARE MADE IN ADVANCE.***