



CENTER FOR DIABETES, ENDOCRINOLOGY & NUTRITION, INC
400 Camarillo Ranch Road
Camarillo, CA 93012
Phone: 805-482-5550
Fax: 805-233-6367

Welcome to the Center for Diabetes, Endocrinology & Metabolism!

We are pleased you have chosen us to assist you with your health care. We will do everything possible to make your experience with us satisfying and productive. Enclosed is a New Patient Enrollment Packet that should be completed prior to your first visit.

Here is a checklist of things to bring with you to your first visit:

- Patient Registration Form
- Office Policies and Notice of Privacy Practices Forms. Please read and sign both forms. If you have any questions regarding this information, please ask.
- Personal Health History Form
- Review of Systems Form
- Patients with Diabetes. If you have diabetes, please complete the diabetes history form as well. Also, please bring your blood sugar meter and blood sugar record. For the week prior to your visit, we request that you check your sugars 4 times a day (before each meal and bedtime) and bring these numbers written down to your appointment.
- Insurance Card. Please bring your insurance card and personal identification.
- Referral. If you have an HMO insurance plan, please bring the required referral from your primary care physician.
- Medical Records. It is helpful to bring pertinent medical information to your visit, including: recent labs, scans, and reports. If you do not have this information, you may call your primary care physician's office and request them to fax a copy of your pertinent medical records to us.
- Medications. Please bring all of your medication bottles (including over-the-counter vitamins and supplements) to your visit.

We look forward to seeing you soon! If you have any questions, please contact us.

Thank You,
Center for Diabetes, Endocrinology & Metabolism

CENTER FOR DIABETES, ENDOCRINOLOGY & NUTRITION, INC

PATIENT REGISTRATION FORM

New Patient Information Update Date Completed _____

Name (First, MI, Last):		Home Ph:
Address (Street, City, State, Zip):		Social Security #:
Sex:	DOB:	Marital Status:
Employer:	Job Title:	Day Ph: Evening Ph:
SPOUSE OR GUARDIAN INFORMATION		
Name of patient's spouse or guardian (if patient is a minor):		Relationship to patient:
Address (Street, City, State, Zip) **if different than patient's**		
Phone #:	DOB:	Social Security #:
Employer:	Emergency contact number:	
REFERRING PHYSICIAN INFORMATION		
Referred by:	NPI Number:	Office Phone #:
Address:		
POLICY HOLDER INFORMATION		
Primary Insurance Carrier:	Secondary Insurance Carrier:	Tertiary Insurance Carrier:
Policy Holder's Name:	Policy Holder's Name:	Policy Holder's Name:
Group #:	Group #:	Group #:
ID#:	ID#:	ID#:
Specialist Co-pay amount:	Specialist Co-pay amount:	Specialist Co-pay amount:
Deductible amount:	Deductible amount:	Deductible amount:
INSURANCE VERIFICATION (for office staff to complete before visit)		
<input type="checkbox"/> Verify Eligibility	<input type="checkbox"/> Verify Primary or Secondary	<input type="checkbox"/> Authorization required from PMD?
<input type="checkbox"/> Verify Specialist Co-pay	<input type="checkbox"/> Verify Deductible & Amount Met	
<input type="checkbox"/> Confirm address for claim to be sent:		
<input type="checkbox"/> Verify Insurance Electronic Payer ID Number:		
Insurance verification completed by (staff name & date):		

AUTHORIZATION:

1. While at the Center for Diabetes & Endocrinology, I consent to all medical care, examinations and tests determined to be necessary for me. Though I expect the care given will meet customary standards, I understand there are no guarantees concerning the results of my care. If I refuse treatment that is suggested for me or do not complete any treatment protocol recommended to me, I will not hold the Center for Diabetes & Endocrinology or any individual responsible for any of the consequences.
 2. I authorize assignment of benefits due to be paid directly to Center for Diabetes & Endocrinology. I understand I am financially responsible for the charges not covered by this authorization.
 3. I authorize the Center for Diabetes to release any information required to my insurance company to process my claims.
 4. I hereby authorize my physician to release information to my referring doctor and/or Primary Care Physician(s).
 5. I understand all of the above and hereby state that the information provided is correct. I understand I am financially responsible for delays or denials of insurance claims due to incorrect information.
- My signature indicates that I have read the above and grant the request of authorizations.

Patient Signature: _____ Date: _____

CENTER FOR DIABETES, ENDOCRINOLOGY & NUTRITION, INC
OFFICE POLICIES

1. Insurance contracts are between the insurance company and the patient. It is the patient's responsibility to know what services are covered by his/her insurance plan. All services provided by The Center for Diabetes & Endocrinology not covered by the insurance plan will become the responsibility of the patient. If the insurance information is not provided at the time of service, the patient will be seen on a cash pay basis.
2. If the patient has no insurance and/or is a self-payer, they should make payment arrangements before services are rendered.
3. If the patient is a member of an insurance plan which requires a Referral/ Authorization for his/her visits, the patient is responsible for obtaining and keeping current Authorizations for each visit. Failure to do so will result in unpaid charges which will be billed directly to the patient.
4. Co-pay is due in full at the time of service. If you are unable to provide the co-pay, a \$10.00 billing fee will be added to your account. For any returned checks, a fee of \$25.00 will be charged.
5. Past due amounts that are greater than 90 days overdue are subject to being turned over to a collection agency. You are strongly encouraged to pay all past due amounts promptly or set up a payment plan with us.
6. If you are not able to keep your appointment, we request that you call at least 72 hrs in advance, so that we may be able to provide more timely care to other patients who could be scheduled into your reserved time slot. We require at least 24 hours notice for the cancellation of all appointments. A \$25 charge will be added to your account if 24 hours notice is not received prior to a missed appointment.
7. All refills should be done during office visits. If seen within the last 60 days, you may request a prescription refill by calling your pharmacy and asking them to send us an electronic refill request. Also, please plan ahead. Prescriptions will be refilled within 72 hours of the office receiving the request. No prescriptions will be provided after hours or on weekends.
8. Any and all paperwork or forms that the physicians are requested to complete need to be done by special office visit appointment. This includes, but not limited to: DOT physicals, FMLA, disability, social security, etc.
9. Please make a list of questions for your doctors/educators prior to your visit. If you have questions after you leave your visit, you must make follow-up appointments. We cannot answer questions and treat patients over the phone. If you mail or fax questions, they will be put in the chart to be addressed at the next visit.
10. When patients are requesting medical records, the patient must complete an "Authorization for Release of Medical Information." There is a processing fee payable at time of request. Requests are usually handled within 15 business days.
11. We accommodate walk-in appointments as often as possible for patients with acute needs or urgent refill requests. If you need medical care when the office is closed, you can go to the nearest walk-in clinic. In case of an emergency, call 911 and go to the nearest emergency room.

If you have any questions regarding the above information, please ask.

Patient Signature:

Date:

Patient Printed Name:

CENTER FOR DIABETES, ENDOCRINOLOGY & NUTRITION, INC
SUMMARY OF HIPAA NOTICE OF PRIVACY PRACTICES

The Center for Diabetes & Endocrinology complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The Center for Diabetes & Endocrinology protects confidential health care information, known as "Protected Health Information" (PHI). Below is a summary of your privacy rights under HIPAA. The Center for Diabetes & Endocrinology legal duties and privacy practices regarding your PHI are also included in this Summary Notice.

Summary of Your Privacy Rights

The Center for Diabetes & Endocrinology may use and give your health information to:

- Treat you
- Get paid
- Operate health care services

The Center for Diabetes & Endocrinology may use and give your health information for:

- Law enforcement requests
- Judicial and administrative proceedings related to legal actions
- Healthcare fraud and abuse detection or compliance with the law
- Use by another healthcare provider treating you
- Government health oversight activities
- Reports required by law related to births, deaths or diseases
- Reports required by law related to neglect and abuse, or domestic violence
- Notifying a party about exposure to a possible communicable disease
- Use by another healthcare provider for payment to that provider
- Military, national defense and security or other governmental functions
- Workers' compensation purposes and in compliance with related laws
- Averting a serious threat to public health and safety

You have the right to:

- Inspect or get a copy of your medical record
- Change information on your medical record if you think it is incorrect
- Get a list of persons whom The Center for Diabetes & Endocrinology shared your PHI
- Ask The Center for Diabetes & Endocrinology to limit the information it shares
- Ask for a copy of your privacy notice
- Write a letter of complaint to The Center for Diabetes & Endocrinology or the federal government

The complete text of the Notice of Privacy Practices as described by HIPPA law can be found online at: www.hhs.gov/ocr/privacy/hipaa/understanding/coveridentities/notice.html or by asking for a copy from The Center for Diabetes & Endocrinology staff. Please read this complete notice before receiving services.

If you have any questions or if you wish to file a complaint, or exercise any rights listed in this Summary or the complete Notice, please contact one of The Center for Diabetes & Endocrinology physicians or staff.

** I have reviewed a copy of the Center for Diabetes, Endocrinology & Metabolism's Notice of Privacy Practices. I have had an opportunity to read the Notice of Privacy Practices and I understand that I may ask questions to the Center for Diabetes, Endocrinology & Metabolism if I do not understand any information contained in the Notice of Privacy Practices.

Patient Signature:

Date:

Patient Printed Name:

CENTER FOR DIABETES, ENDOCRINOLOGY & NUTRITION, INC
PERSONAL HEALTH HISTORY INFORMATION

All questions contained in this questionnaire are strictly confidential and will become part of your medical record

Name (First, MI, Last):	Date:	Date of Birth:
Reason for referral to our practice:		
MEDICAL HISTORY		
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Heart Trouble	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Asthma, Hay Fever	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Thyroid Disorder	<input type="checkbox"/> Pneumonia	
<input type="checkbox"/> Other past or current medical condition:		
Surgeries:		
Hospitalizations/Major Injuries:		
Significant health conditions of your family members:		
MEDICATIONS		
List your medications, including: prescribed drugs, birth control, pain medication, sleep aids, over-the-counter vitamins and supplements. (Include name, strength, frequency taken)		
List Allergies or Adverse Reactions to medications or other substances below:		(Include drug name and allergic reaction)
SOCIAL HISTORY		
What do you do for exercise?		
What do you do for relaxation?		
What methods do you use to control your weight?		
Do you use: (Place an X in the box next to those you use)		
<input type="checkbox"/> Cigarettes <input type="checkbox"/> Pipe <input type="checkbox"/> Cigars <input type="checkbox"/> Chewing tobacco <input type="checkbox"/> Beer <input type="checkbox"/> Wine <input type="checkbox"/> Hard liquor <input type="checkbox"/> Recreational drugs		
SEXUAL/MENSTRUAL HISTORY		
Are you sexually active?	Are you using birth control? Which type?	
When was your last period?	Are you trying to become pregnant?	

CENTER FOR DIABETES, ENDOCRINOLOGY & NUTRITION, INC

REVIEW OF SYSTEMS

Name (First, MI, Last):		Date:	Date of Birth:
PLACE AN X IN ANY BOX NEXT TO A PROBLEM OR DISTURBANCE YOU HAVE HAD IN THE PAST YEAR			
CONSTITUTION	<input type="checkbox"/> Recent weight changes	<input type="checkbox"/> Changes in appetite	<input type="checkbox"/> Persistent fever
	<input type="checkbox"/> Night sweat-hot flashes	<input type="checkbox"/> Heat or cold sensitivity	<input type="checkbox"/> Tire easily
	<input type="checkbox"/> Weakness or paralysis		
SKIN/HAIR/NAILS	<input type="checkbox"/> Skin rash	<input type="checkbox"/> Dry skin	<input type="checkbox"/> Change in hair or nails
	<input type="checkbox"/> Excessive perspiration	<input type="checkbox"/> Skin itching	<input type="checkbox"/> Wounds
EYES	<input type="checkbox"/> Eye pain	<input type="checkbox"/> Eye redness	<input type="checkbox"/> Blurred / double vision
	<input type="checkbox"/> Glasses or contacts	<input type="checkbox"/> Infected eyes	
EARS	<input type="checkbox"/> Ringing in the ears	<input type="checkbox"/> Discharge from ears	<input type="checkbox"/> Ear pain
	<input type="checkbox"/> Decrease in hearing		
NOSE	<input type="checkbox"/> Frequent nose bleeds	<input type="checkbox"/> Stuffiness / discharge	<input type="checkbox"/> Loss/lack of smell
MOUTH	<input type="checkbox"/> Sore tongue or gums	<input type="checkbox"/> Bleeding gums	<input type="checkbox"/> Persistent hoarseness
NECK	<input type="checkbox"/> Neck swelling	<input type="checkbox"/> Neck stiffness	<input type="checkbox"/> Sore throat
CHEST	<input type="checkbox"/> Frequent cough	<input type="checkbox"/> Wheezing	<input type="checkbox"/> Shortness of breath
	<input type="checkbox"/> Bloody sputum	<input type="checkbox"/> Painful breathing	<input type="checkbox"/> Chest pain/discomfort
HEART	<input type="checkbox"/> Swelling of hands/ feet	<input type="checkbox"/> Palpitations	<input type="checkbox"/> Leg cramp on walking
	<input type="checkbox"/> Heartburn	<input type="checkbox"/> Enlarged veins	
STOMACH/BOWELS	<input type="checkbox"/> Abdominal cramping	<input type="checkbox"/> Nausea/Vomiting	<input type="checkbox"/> Chronic diarrhea
	<input type="checkbox"/> Chronic constipation	<input type="checkbox"/> Rectal bleeding	<input type="checkbox"/> Black tarry stools
URINARY TRACT	<input type="checkbox"/> Frequent urination	<input type="checkbox"/> Increase in thirst	<input type="checkbox"/> Painful urination
	<input type="checkbox"/> Leakage of urine	<input type="checkbox"/> Blood in urine	
GENITAL	<input type="checkbox"/> Lack of sex drive	<input type="checkbox"/> Painful sex	
NEURO	<input type="checkbox"/> Numbness/tingling	<input type="checkbox"/> Tremor	<input type="checkbox"/> Headaches
	<input type="checkbox"/> Memory loss	<input type="checkbox"/> Sleep changes	<input type="checkbox"/> Depressed mood
MUSCLES	<input type="checkbox"/> Backaches	<input type="checkbox"/> Joint pain or stiffness	<input type="checkbox"/> Swollen joints
	<input type="checkbox"/> Muscle cramps/spasms		
MEN ONLY	<input type="checkbox"/> Difficulty with erection	<input type="checkbox"/> Testicle lump/pain	<input type="checkbox"/> Penis discharge
WOMEN ONLY	<input type="checkbox"/> Period absent	<input type="checkbox"/> Days between period	<input type="checkbox"/> Heavy flow
	<input type="checkbox"/> Menstrual pain/cramps	<input type="checkbox"/> Bloody discharge	<input type="checkbox"/> Other discharge
	<input type="checkbox"/> Breast lump/discharge	<input type="checkbox"/> Breast pain	Date last mammogram:
	# Pregnancies: _____	# Living births: _____	_____

Is there anything else you would like your doctor to know? _____

CENTER FOR DIABETES, ENDOCRINOLOGY & NUTRITION, INC

DIABETES HISTORY FORM

Please complete this form only if you have diabetes . Print and bring to your visit.

Name (First, MI, Last):	Date:	Date of Birth:
What year were you diagnosed with diabetes? How old were you?		
Have you ever had any diabetes related complications?		
<input type="checkbox"/> High blood pressure?	<input type="checkbox"/> Diabetic eye disease or previous laser treatment?	
<input type="checkbox"/> High cholesterol?	<input type="checkbox"/> Nerve problems (numbness/tingling)?	
<input type="checkbox"/> Heart attack or Chest pain /pressure with walking?	<input type="checkbox"/> Kidney problems or protein in your urine?	
<input type="checkbox"/> Stroke or TIA?	<input type="checkbox"/> Foot ulcers or deformities?	
<input type="checkbox"/> Pain /cramps in lower legs with walking?	<input type="checkbox"/> Dental problems or Gum disease?	
<input type="checkbox"/> Erectile dysfunction?	<input type="checkbox"/> Depression?	
Have you ever been hospitalized for uncontrolled blood sugar? When & where?		
What insulin and other medications (names, doses, frequency) do you take for diabetes?		
If you take insulin, what year did you start?		
Do you check your blood sugars at home?	(Please always bring your meter to your appointment)	
During the past month, what have your sugars been:		
Fasting/pre-breakfast sugars:	Highest:	Lowest: Average:
Pre-lunch sugars:	Highest:	Lowest: Average:
Bedtime sugars:	Highest:	Lowest: Average:
What year did you get your last pneumonia vaccination?		
**If you have not had a pneumonia vaccination: The Centers for Disease Control (CDC) recommends that all people with diabetes receive a pneumonia vaccination to reduce your chance of getting a bacterial pneumonia infection. It protects against 23 types of pneumococcal bacteria. It is recommended once before the age of 65 and once after the age of 65 but not within 5 years of a previous pneumonia vaccination.		
Have you had a flu shot during this flu season (between October and February)?		
**If you have not had a flu shot: A yearly flu shot is recommended to people with diabetes.		
When was your last eye exam?		
**It is recommended that all people with diabetes have a yearly eye exam.		
Do you smoke tobacco?	If Yes, how many packs per day?	

Please remember to bring your blood sugar meter and blood sugar record to your appointment. For the week prior to your visit, we request that you check your sugars 4 times a day (before each meal and bedtime) and bring these numbers written down to your appointment.

Please bring all of your medication bottles with you to your visit