SUBURBAN ENDOCRINOLOGY AND DIABETES

MAIN OFFICE:
2101 S. ARLINGTON HEIGHTS ROAD, SUITE 111
ARLINGTON HEIGHTS, IL 60005
(847) 228-3200
FAX (847) 228-3740
www.subendo.com

27750 W. HIGHWAY 22
BUILDING 2, SUITE 120
BARRINGTON, IL 60010
(847) 228-3200

L. FERNANDO SORUCO, M.D.
MARIO H. CHAN, M.D.
DANIEL D. SO, M.D.

PARASKEVI SAPOUNTZI, M.D.
KARA FINE, M.D.
NICOLE LORANG, NP-C

PLEASE PRINT

Patient Information:

Date _____ E-Mail Address _____

Name _____ Social Security # _____

Address _____ City, State, Zip _____

Home Phone# (_____) _____ Work Phone# (_____) _____

Employer _____ Occupation _____

Address _____ City, State, Zip _____

Cell Phone# (_____) _____ Birthdate _____ Sex _____ Marital Status _____

Guarantor/Insured Information:

Name of Insured _____ Social Security# _____

Insurance Company _____ DOB _____ Relationship _____

Employer _____ Occupation _____

Address _____ Work Phone# (_____) _____

City, State. Zip _____

Pharmacy Information:

Name _____ Address _____

City, State, Zip _____ Phone# (_____) _____

Name _____ Address _____

City, State, Zip _____ Phone# (_____) _____

Name of physician that referred you? _____

Address _____ Phone# (_____) _____ Fax# (_____) _____

Who is your primary care physician: Dr. _____

Address _____ Phone# (_____) _____ Fax# (_____) _____

Please note: if pre-authorization is necessary, it is your responsibility to be sure we are alerted. We suggest you call the pre-authorization line to make sure we have given them the correct information. Thank you.

I,_____, hereby acknowledge receipt of the Physician's Notice of Privacy Practices. The Notice of Privacy Practice provides detailed information about how the practice may use and disclose my confidential information.

I understand that the physician has reserved a right to change his or her privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be provided to me or made available.

Signed_____ Date _____

If you are not the patient, please specify your relationship to the patient _____

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Dear Patient:

Our office is most happy to complete and submit claims to primary insurance plans. Please keep in mind that most insurance companies do not cover all procedures. We encourage you to discuss any questions you may have regarding your specific plan with our management. We encourage you to contact your insurance company to determine what coverage your plan provides.

Please read and sign below showing you understand the following:

- I understand that my insurance may/may not cover all medical services and that it is my responsibility to call the insurance company to verify coverage and to confirm that the doctor I am seeing is in the network.
- I understand that it is my responsibility to provide referrals or pre-authorization for services as required by my insurance plan.
- My insurance plan may have a deductible and/or co-payment amount. All co-pays are due at the time of service. Payment is **your** obligation regardless of insurance or other third party involvement.
- I accept full responsibility for all fees required for my child's medical care regardless of my marital status.
- I understand that missed appointments and cancellations without adequate notice (more than 24 hours notice) will incur a $35 charge for existing patients and a $60 charge for new patients prior to or at your next visit.
- In the event that I/my family want to transfer to another office, I understand that my balance must be paid in full to receive copies of medical records. There is a charge for duplication of medical records.
- I understand that if my check payment is returned as NSF from the bank there is a $35 NSF charge, which will be added to my account.
- I understand there is a $5 surcharge if I do not pay my co-pay on the date of service.
- I understand that I am responsible for any reasonable fees, expenses, or costs related to the collection of any unpaid balance, including commissions paid to attorneys or collection agencies.

Patient/Parent Signature _____ Date _____

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PATIENT INFORMATION AUTHORIZATION

I,_____ authorize the methods of communication of my protected health information (PHI) as indicated below. I understand under the HIPAA guidelines my patient information is held confidential unless authorized by my signature.

The following person(s) can inquire, pick up records, prescriptions, etc., and take messages regarding my health information:

1._____ Relationship:_____

2._____ Relationship:_____

3._____ Relationship:_____

4._____ Relationship:_____

Suburban Endocrinology & Diabetes is authorized to communicate PHI such as lab results, physician messages, or appointment information. Please initial each appropriate line that you authorize:

_____ Telephone answering machine

_____ With a person listed above

_____ Mail to: ☐ Home / ☐ Office

_____ Fax Machine

Signature of Patient or Legal Guardian_____

Patient's Name_____ Date_____

Print Name of Patient or Legal Guardian_____

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PHONE: (847) 228-3200

PERMISSION TO RELEASE MEDICAL RECORDS

Patient's Name _____
(First) (Middle) (Last)

Date of Birth _____ Social Security Number _____

Medical Record # _____

☐ **PERMISSION IS HEREBY GRANTED FOR RELEASE OF MEDICAL INFORMATION FROM SUBURBAN ENDOCRINOLOGY & DIABETES CENTER AND TO BE FORWARDED TO:**

From/To: _____

_____

_____

The following information may be released:

_____Laboratory Date
_____Radiology Reports
_____Pathology Reports
_____Other
_____Progress/Doctors Notes
_____Medication Records
_____All Records

_____ _____
(Patient's Signature) (Date)

_____ _____
(Witness) (Date)

MEDICATION LOG

PATIENT NAME: _____

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Medication & Dosage	DATE:							

NEW PATIENT INFORMATION FORM

SUBURBAN ENDOCRINOLOGY AND DIABETES

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Patient:_____ Date:_____

How many finger sticks / day_____ ☐ Pen ☐ Vial

HISTORY:

REASON FOR VISIT (chief complaint): _____

TO BE FILLED OUT BY M.D.

HISTORY OF PRESENT ILLNESS: • For a Level 3, 4, 5, history, document at least 4 of these elements or status of ≥ 3 chronic or inactive problems

- Location _____ • Quality _____
- Severity _____ • Duration _____
- Timing _____ • Context _____
- Associated signs/symptoms _____ • Modifying factors _____

MEDICAL HISTORY:

- For a level 3 history - at least 1 specific item for ANY ONE of the 3 histories
- For a level 4 & 5 history - at least 1 specific item for EACH ONE of the 3 histories

(A) • Patient medical history/past history

Diabetes	No	Yes
Hypertension	No	Yes
Cancer	No	Yes
Stroke	No	Yes
Heart trouble	No	Yes
Thyroid	No	Yes

Other:_____

_____

_____

_____

_____

Previous Hospitalizations/Surgeries/Serious Injuries When?

_____

_____

_____

_____

Radiation Treatment (Type & Age)_____

Medications and doses

_____

_____

_____

Past medications: _____

(B) • Patient social history

Marital status: Single____ Married____ Separated____ Divorced____ Widowed____

Use of alcohol: Never____ Rarely____ Moderate____ Daily____

Use of tobacco: Never____ Previously, but quit____ Current packs/day____

Use of drugs: Never____ Type/Frequency_____

(C) • Family medical history Disease

	Age	Diabetes	Heart Disease	Hypertension	Thyroid	Cancer	Other	If Deceased, Cause of Death
Father								
Mother								
Siblings								
Spouse								
Children								

NEW PATIENT INFORMATION FORM

SUBURBAN ENDOCRINOLOGY AND DIABETES

PATIENT NAME _____

SYSTEM REVIEW:
- For a level 3 system review - at least 2 systems
- For a level 4 & 5 system review - at least 10 systems (Dictate responses to pertinent systems, then state "All other systems negative")

• CONSTITUTIONAL SYMPTOMS No Yes

Good general health lately ..... No Yes
Recent weight change Gain? Or loss? ..... No Yes
Fever, chills ..... No Yes
Fatigue ..... No Yes
Height loss ..... No Yes

• EYE PROBLEMS No Yes

Eye bulging ..... No Yes
Eye lid problems ..... No Yes
Wear glasses/contact lens ..... No Yes
Blurred or double vision ..... No Yes

• EARS/NOSE/MOUTH/THROAT PROBLEMS No Yes

Hearing loss or ringing ..... No Yes
Dental problems ..... No Yes
Sore throat or voice change ..... No Yes
Swollen glands in neck ..... No Yes

• CARDIOVASCULAR PROBLEMS No Yes

Heart trouble What Kind _____ No Yes
Chest pain or angina pectoris ..... No Yes
Palpitations ..... No Yes
Shortness of breath with walking or lying flat ..... No Yes
Swelling of feet, ankles or hands ..... No Yes
Fainting ..... No Yes

• RESPIRATORY PROBLEMS No Yes

Chronic or frequent coughs ..... No Yes
Shortness of breath ..... No Yes
Asthma or wheezing ..... No Yes

• GASTROINTESTINAL PROBLEMS No Yes

Loss of appetite ..... No Yes
Nausea or vomiting ..... No Yes
Frequent diarrhea or frequent BM ..... No Yes
Painful bowel movements or constipation ..... No Yes
Abdominal pain ..... No Yes
Peptic ulcer (stomach or duodenal) ..... No Yes

• GENTIOURINARY PROBLEMS No Yes

Frequent urination ..... No Yes
Kidney stones ..... No Yes
Fertility problems ..... No Yes
Female – irregular periods ..... No Yes
Female – # pregnancies _____ # miscarriages _____
Female – # live births _____
Female – date of LMP _____
Female – age of 1st period _____
Male – age when started shaving _____
Male – erectile problem ..... No Yes

• MUSCULOSKELETAL PROBLEMS No Yes

Joint pain ..... No Yes
Joint stiffness or swelling ..... No Yes
Weakness of muscles ..... No Yes
Muscle pain or cramps ..... No Yes
Back Pain ..... No Yes
Fracture, which bone _____ No Yes

• (BREAST/SKIN) INTEGUMENTARY PROBLEMS No Yes

Breast pain or enlargement ..... No Yes
Breast lump ..... No Yes
Nipple discharge ..... No Yes

Rash or itching ..... No Yes
Change in skin color ..... No Yes

Change in hair or nails ..... No Yes

• NEUROLOGICAL PROBLEMS No Yes

Headaches ..... No Yes
Light headed or dizzy ..... No Yes
Convulsions or seizures ..... No Yes
Numbness or tingling sensations Where _____ No Yes
Tremors ..... No Yes
Paralysis ..... No Yes
Stroke ..... No Yes
Neuropathy ..... No Yes

Acne ..... No Yes
Excessive sweating ..... No Yes

• PSYCHIATRIC PROBLEMS No Yes

Nervousness/anxiety ..... No Yes
Depression ..... No Yes
Insomnia/poor sleep ..... No Yes

• ENDOCRINE PROBLEMS No Yes

Glandular or hormone problem which one _____ No Yes
Thyroid disease ..... No Yes
Diabetes ..... No Yes
Excessive thirst ..... No Yes
Heat or cold intolerance ..... No Yes
Skin becoming dryer ..... No Yes
Change in hat, glove, shoe or ring size ..... No Yes

• HEMATOLOGIC/LYMPHATIC PROBLEMS No Yes

Anemia ..... No Yes
Enlarged lymph glands ..... No Yes
Blood clots ..... No Yes

• ALLERGIC IMMUNOLOGIC PROBLEMS No Yes

History of adverse reaction to:
Drugs _____
Other _____

M.D. Initials	Date	M.D. Initials	Date