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 _____

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

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_____