# Associated Endocrinologists, PC

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**PLEASE PRINT** Account No. _____

Patient Name _____ Marital Status M___ S___ W___ D___

Referred by_____ Primary Care Dr _____

Address (Home) _____ Home Phone (_____) _____

_____ Cell Phone (_____) _____

Email Address _____

City _____ State _____ Zip Code _____

Social Security _____-_____-_____ Date of Birth _____-_____-_____ Age_____ Sex _____

Patient Occupation _____ Employer _____

Business Address_____ Phone (_____) _____
Spouse or
Subscriber Name _____ Soc. Sec. No. _____-_____-_____

Subscriber Date of Birth _____-_____-_____Address_____
Subscriber's
Employer _____ Phone (____) _____
Person to contact in case of emergency: Name _____
Relationship _____ Phone (_____) _____

I DO/DO NOT (Please Circle One) give permission to leave medical information on my answering machine.
I DO/DO NOT (Please Circle One) give permission to discuss my healthcare with family members.
Please specify name: _____ Relationship _____ Phone (___) _____
Please specify name: _____ Relationship _____ Phone (___) _____

I hereby authorize my insurance benefits to be paid directly to the above physician, realizing I am responsible to pay Non-covered services and I hereby authorize the release of pertinent medical information to insurance carriers.
_____ (initial)

By signing below, I acknowledge that I have reviewed the NOTICE OF PRIVACY PRACTICES from Associated Endocrinologists, P.C.
_____ (initial)

DOCUMENTATION OF FAILURE TO OBTAIN SIGNED ACKNOWLEDGMENT
On (date) _____ (name of employee) _____ presented this Acknowledgment of Receipt of Notice of Privacy Practices Form to (patient's name) _____.
The patient refused _____ or could not _____ provide a signature when requested.
_____ (initial)

**Signature _____ Date _____**

Signature (Authorized Representative) _____