SUBURBAN ENDOCRINOLOGY ASSOCIATES, P.C.

MARILYN RYAN, M.D., F.A.C.E.
SHALINI VIJAYKUMAR, M.D.
AMY IWAMAYE, M.D.

11 Industrial Blvd., Suite 202
Paoli, PA 19301

Telephone: (610) 251-0300
Fax: (610) 251-0304

WELCOME TO SUBURBAN ENDOCRINOLOGY ASSOCIATES.

Upon your initial visit with us, please bring your insurance card(s) and photo ID so that we may scan them into your EMR.

It is imperative that you or your referring physician send any lab or test results, written reports of any testing, i.e. ultrasounds, scans, etc., that you may have had done in the past in reference to your endocrine issue. Please forward all test results and the attached new patient documents, to us no later than two weeks prior to your scheduled appointment. You may either mail, stop by with them, or fax to us at 610-251-0304. If you are being seen for diabetes, please bring two weeks of blood sugar readings with you to the appointment.

If your insurance is an HMO requiring a referral, please make sure that your referral is available at the time of your visit. You will not be seen without a valid referral. For all insurances, copays are due at the time of the visit. We accept cash, checks, and major credit cards.

We are located in the Paoli Pointe Building which is next to Paoli Hospital. We are on the second floor, simply exit right out of the elevator and enter Suite 202. We look forward to seeing you and please call us with any questions.

Thank you,

Suburban Endocrinology Associates

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Name:_____ Age:_____ Date of Birth: ___/___/_____

Address:_____

City: _____State: _____Zip Code:_____

Phone Home: _____/_____/_____Cell: _____/_____/_____ Work:_____/_____/_____

Patient Portal: Email-address: _____

Primary Insurance Company:_____

Subscriber's Name:_____

Relationship to Patient:_____ Insured's DOB:_____/_____/_____

Member's ID #: _____Group #:_____

Secondary Insurance Company:_____

Subscriber's Name:_____

Relationship to Patient:_____Insured's DOB:_____/_____/_____

Member's #:_____ Group #:_____

Referring Physician and/ or Family Physician:_____

Phone#:___/_____/_____ Fax#:_____/_____/_____

Address:_____

Pharmacy: _____Phone #:_____/_____/_____

Address:_____

I AUTHORIZE RELEASE OF INFORMATION TO ALL OF MY INSURANCE COMPANIES
I AUTHORIZE PAYMENT DIRECTLY TO MY DOCTOR
I UNDERSTAND THAT I AM RESPONSIBLE FOR MY ACCOUNT WITH SUBURBAN END ASSOC, PC.
I permit a copy of the authorization to be used in place of the original
I HAVE READ THE ABOVE AND UNDERSTAND ALL STATEMENTS ABOVE.

Please sign: _____Date: ___/___/_____

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PATIENT QUESTIONNAIRE

Name:_____ Date:_____

Please take a few minutes to give us the following information. It will assist us in getting to know you better.

Reason for your visit today:_____

Please circle if you have haw or have ever had any of the following:

Cancer	Rheumatic Fever	Asthma	Goiter
Kidney Stones	Heart Problems	Cataracts	Diabetes
Epilepsy	Nervous Breakdown	Stomach Ulcers	Stroke
Bad Headaches	High Blood Pressure	High Cholesterol	Colitis
Pneumonia	Kidney Disease	Anemia	Past Fractures
Pituitary Tumors	Osteoporosis	Childhood Neck	Irradiations

Other Significant Illness/Injuries:_____

Previous Operations: Year:

_____ _____

_____ _____

_____ _____

Allergies:_____

FAMILY HEALTH PROBLEMS

Father:_____ Paternal Grandmother:_____

Mother: _____ Paternal Grandfather:_____

Your Children: _____ Maternal Grandmother:_____

Brother(s):_____ Maternal Grandfather:_____

Sister(s): _____ Aunt(s):_____

_____ Uncle(s):_____

Do other family members not listed above have any of the following? (Circle any that apply.)

Diabetes	Thyroid Disease	High Cholesterol	Kidney Stones
Osteoporosis	Heart Disease	Hypertension	Strokes
Hormone Problem			

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Married_____ Divorced_____ Widowed_____ Single_____

Whom do you live with?_____

Children:_____

Occupation:_____ Hours:_____ Retired?_____

Smoke: Y / N Amount: _____Date Quit:_____ Amt/Years smoked:_____

Alcohol Use: Y / N Frequency:_____

Drug Use: Y / N Quit: _____ Type:_____

Exercise: Y / N Type:_____ Frequency:_____

Previous Prescribed Diet: Y / N Type:_____

Time of Meals and Daily Schedule:

Arise_____ Lunch_____ Supper_____ Snacks_____ Bedtime_____

MEDICATIONS:

Name of Medication	Strength	Directions

Reviewed with Patient: Signature_____Date:_____

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GENERAL
0 Recent weight gain
0 Recent weight loss
0 Fatigue
0 Weakness
0 Trouble sleeping
0 Excessive thirst

NERVOUS SYSTEM:
0 Headaches
0 Dizzy / Lightheaded
0 Shaking
0 Fainting
0 Loss of consciousness
0 Sensitivity / pain in hands or feet
0 Memory loss

EYES
0 Pain
0 Redness
0 Loss of vision
0 Double / blurred vision
0 Dryness
0 Change in appearance of eyes

MENTAL
0 Anxiety
0 Mood swings
0 Trouble concentrating

NOSE:
0 Nosebleeds
0 Loss of smell

MOUTH:
0 Bleeding gums
0 Sores in mouth
0 Loss of taste
0 Dryness

HEART AND LUNGS:
0 Chest discomfort
0 Sudden changes in heartbeat
0 Shortness of breath
0 Difficulty breathing at night
0 Swollen legs and feet
0 Rapid heartbeat
0 Heart murmurs
0 Cough
0 Coughing of blood
0 Wheezing
0 Night sweats

STOMACH AND INTESTINES:
0 Nausea
0 Vomiting
0 Stomach pains
0 Increasing constipation
0 Yellow jaundice
0 Blood in stool
0 Heartburn
0 Appetite changes
0 Early fullness when eating

KIDNEY/BLADDER URINE:
0 Difficult urination
0 Pain or burning on urination
0 Blood in urine
0 Cloudy urine
0 Discharge from penis/vagina
0 Frequent urination
0 Periods regular
0 Urination during the night
0 Vaginal dryness
0 Sexual difficulties
0 Prostate trouble

BLOOD:
0 Bleeding tendency

OTHER:

_____
_____
_____
_____

SKIN:
0 Easy bruising
0 Redness / rash
0 Sun sensitivity
0 Breast discharge
0 Enlarged breast (Males)
0 Nodules / bumps
0 Hair loss
0 Excessive hair
0 Stretch marks

MUSCLES/JOINTS/BONES:
0 Muscle weakness
0 Muscle tenderness
0 Muscle cramps
0 Muscle spasms

THROAT:
0 Frequent sore throats
0 Hoarseness
0 Difficulty swallowing

NECK:
0 Swollen glands
0 Tender glands
0 Enlarged thyroid
0 Neck lumps

MENSTRUAL:
0 Not applicable
Age periods began_____
0 Periods irregular
0 PMS
Date last PAP_____
Date last mammogram_____
Date menopause_____
0 Bleeding after menopause

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HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The IDP AA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments?	YES	NO
May we leave a message on your answering machine at home or on your cell phone?	YES	NO
May we discuss your medical condition with any member of your family?	YES	NO

If YES, please name the members allowed:

_____

_____

This consent was signed by: _____

(PRINT NAME PLEASE)

Signature: _____ Date: _____

Witness: _____ Date: _____