North Texas Diabetes & Endocrinology

Demographic Information

Patient Name	**Date of Birth**	**Sex** Male / Female
Social Security Number / **Email**		**Marital Status** Single / Married / Widowed / Divorced / Other
Mailing Address	**City/State**	**Zip Code**
Primary Phone	**Secondary Phone**	**How did you hear about us?** ☐ Google ☐ Physician Referral ☐ Other: _____

I authorize detailed messages containing pertinent medical information to be left in a voicemail at the following numbers:
□Primary Phone □ Secondary Phone □ Emergency Primary □ Emergency Secondary

Responsible Party □ Self □ Other – Information Below

Name		**Relationship to Patient**
Date of Birth	**Primary Phone**	**Mailing Address** [☐ Check if Same as Above]
Employer's Name		
Emergency Contact	**Emergency's Primary Phone**	**Emergency's Secondary Phone**
Pharmacy Name and Address		**Pharmacy Phone Number**
Ethnicity □ Hispanic or Latino □ Not Hispanic or Latino □ Unknown		**Language** □ English □Other_____
Race □ American Indian or Alaska Native □ Asian □ White □ Other □ Black or African American □ Native Hawaiian or Other Pacific Islander		**Appointment Confirmation Preference** □ Email □ Text

Protected Health Information Authorization

Name	Relationship	Type of Information Authorized
1.		□All □Scheduling □Medical □Billing
2.		□All □Scheduling □Medical □Billing
3.		□All □Scheduling □Medical □Billing

I have reviewed the above information and authorize my protected health information to be released to the individuals listed, as specified. I understand that this authorization applies to both written and verbal communications. I also understand that I may request to revoke this authorization, in writing, at any time.

_____ _____

Signature of Patient/Legal Representative **Date**

Insurance Information

Primary	Secondary	Tertiary
Insurance Company	**Insurance Company**	**Insurance Company**
Name of Insured	**Name of Insured**	**Name of Insured**
Member ID/ Policy #	**Member ID/ Policy #**	**Member ID/ Policy #**
Group #	**Group #**	**Group #**

□ Allen □ Flower Mound □ Irving □ Plano □ Weatherford

North Texas Diabetes & Endocrinology

Patient Financial Policy Sheet

To reduce confusion and misunderstanding between our patients and practice, we have adopted the following financial policies. If you have any questions regarding these policies, please discuss them with us. We are dedicated to providing the best possible care and service to you and regard your understanding of your financial responsibilities as an essential element of your care and treatment.

Unless other arrangements have been made in advance by either you or your health insurance carrier, full payment is due at the time of service. For your convenience, we accept payment by check, cash, debit card, American Express, Discover, Mastercard, or Visa.

Your Insurance

We have made prior arrangements with many insurers and health plans to accept an assignment of benefits. This means that we will bill those plans for which we have an agreement and you may be required to pay a copayment, coinsurance, or deductible at the time of service.

Your assistance in securing timely payments of your claims may be required. If your health plan requires that you obtain prior authorization in the form of a REFERRAL from your primary care physician (PCP), or PRECERTIFICATION before procedures or treatment plans may be initiated, we ask that you inform our staff and assist us to assure these arrangements are made in advance.

If you have insurance coverage with a plan for which we do not have prior agreement, we will prepare and send claims on your behalf. You should be aware however, that the patients' share of the medical fees owed when using non- contracted physicians will usually be more than when using contracted physicians.

Not all services are a covered benefit in all insurance plans. Some health plans select certain services that will not be covered. In the event that your health plan determines a service to be "not covered", you will be responsible for the complete charge. Payment of the balance that is designated as the patients' responsibility is due upon receipt of a statement from our office.

Keep in touch: Do not assume your insurance carrier is "working on it". Contact them if you have not received a notice of payment within 30 to 45 days of your services. If payment is delayed by your health plan, you will be asked to contact them or your health benefits office to identify the issues. You will be held responsible for services not paid by your health plan.

Minor Patients

For all services rendered to minor patients, we will look to the adult accompanying the patient, or the parent or guardian with custody, for payments.

I have read and understand the financial policy of the practice, and I agree to be bound by its' terms. I also understand and agree that the practice may amend such terms from time to time.

Printed Name of Patient	Signature of Patent/Legal Representative	Date

Notice of Receipt of Privacy Practices Notice Acknowledgement

Our practice reserves the right to modify the privacy practices outlined in the notice.

I have reviewed or have been given the opportunity to review this offices' Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of your Notice of Privacy Practices.

** If you would like to receive a copy of our Notice of Privacy Practice, please ask an associate.*

Printed Name of Patient	Signature of Patent/Legal Representative	Date

□ Allen □ Flower Mound □ Irving □ Plano □ Weatherford

North Texas Diabetes & Endocrinology

Cancellation, No Show, and Late Arrival Acknowledgement

In an effort to minimize waiting periods and improve appointment availability we have found it necessary to enact a Patient Cancellation Policy. Any patient that cancels an appointment with less than 24-hour notice and/or does not show up for their appointment will be charged a fee of $75 for the missed appointment. Additionally, after 2 cancellations or no shows without adequate notice, we will no longer be able to accommodate schedule requests. Please be advised that anyone arriving 15 minutes or later to their scheduled appointment will be asked to reschedule their office visit. We hope this policy will ultimately benefit all patients by improving the quality of your treatment experience.

I understand North Texas Diabetes and Endocrinology's cancellation policy, no show policy, and late arrival agreement.

Printed Name of Patient _____ Signature of Patient/Legal Representative _____ Date _____

Prescription Policy

Our practice is a medical office that treats many types of ailments and conditions. On occasion we may prescribe medications for you to help relieve pain. These medications, when used properly, can help patients feel better and lead productive lives. These medications can also be misused, causing harm to patients and to others. For this reason, the State of Texas and the Federal Drug Enforcement Administration regulates use of these medications. Our practice follows those laws:

Our Policy:

1. Written prescriptions will not be replaced if lost, stolen, destroyed, or misplaced.
2. Prescriptions are to be taken as directed. In other words, DO NOT change the frequency of the dose unless otherwise directed by your physician. If a change does occur, this will be documented in your chart.
3. By law, controlled substances cannot be refilled over the phone.
4. Refills for prescriptions listed below may be refilled every three months. As a result, if you were not seen in our office in the past three months, prescriptions for the following cannot be refilled. Exceptions to this must be discussed with the physician during an office visit. Exceptions will not be granted over the phone.
    a. Sleep Aids such as Ambien or Lunesta
    b. Anti-inflammatories such as Celebrex, Ibuprofen, or Naproxen
    c. Narcotics such as Lortab, Vicodin, Darvocet, or Hydrocodone
    d. Muscle Relaxers such as Soma, Flexeril, or Robaxin.
5. If your prescription bottle indicates that you have refills remaining, contact your pharmacy directly. If there are no refills left, you will need to contact our office and schedule an appointment.
6. Refills will NOT be authorized at night, on weekends, or holidays. Be sure to plan ahead to make sure you have enough medication.
7. Before you visit our practice, please check your supply of medication. If you need refills, please ask for them during your appointment.
8. Refill requests for hormone replacement and birth control pills can only be refilled if you have a routine gynecology appointment scheduled. Exceptions to this must be discussed with the physician during an office visit. Exceptions will not be granted over the phone.
9. Refill requests for prescriptions not prescribed by your physician will not be authorized.
10. At least 2 business days are needed for prescription request. Call before Friday.
11. Do not call more than once about a medication, refills, or any issue. When you call our office, a message is sent to your physician. Nothing can be done until your physician has a chance to review the message. The physician is the only one who can approve for your medication to be refilled.

I have read the above prescription policy and I am aware of the necessary steps in order to have prescriptions refilled. I agree to abide by this policy and understand that this signed policy will be scanned into my chart.

Printed Name of Patient _____ Signature of Patient/Legal Representative _____ Date _____

North Texas Diabetes & Endocrinology

Authorized Release of Information

This is a release form for authorization of your medical information to be used/and or disclosed between health care providers health, insurance companies, and any other party involved in your medical care.

I, _____DOB_____, hereby authorize The Facilities Listed below to release all medical information to North Texas Diabetes and Endocrinology. **Please fax records to North Texas Diabetes and Endocrinology of Weatherford - our fax number is (469) 405-5441.**

This request includes: hospital summaries, laboratory reports, physician progress notes, and any other healthcare information relating to my condition.
**List facility name(s), hospital name(s) and/or physician(s) below where you would like your medical records sent.*

Facility / Provider Name	Fax Number

I hereby authorize the above -mentioned provider/facility to release and/or disclose the medical information as indicated below to: North Texas Diabetes and Endocrinology. I also understand this information may contain information relating to Acquired Immunodeficiency Syndrome (AIDS) or infection with Human Immunodeficiency Virus (HIV), mental health and alcohol and/or substance abuse,

DURATION- This information shall become effective immediately and shall remain in effect until ____/____/_____ or for ninety days from the date of signature if no date entered.

REVOCATION: This authorization may be revoked in writing by the undersigned at any time prior to the release of information from the disclosing party. Written revocation will not affect any action taken in reliance on this authorization before the written revocation was received.

REDISCLOSURE: I understand that the requester may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless disclosure is specifically required or permitted by law.

PLEASE SPECIFY RECORDS TO BE RELEASED AND/OR DISCLOSED

( )Entire medical record ( )History and Physical ( )Chart Summary ( )Labs ( )Radiology ( )Pathology

( )Other (Please specify)_____

I request that the health information release and/or disclosed pursuant to this authorization be used for the following purpose only:

( )Physician or Healthcare facility ( )Legal ( )Personal ( )Other _____

A copy of this authorization is valid as an original. I have the right to receive a copy of this authorization. The copy is for me to keep. I understand that there may be a fee for preparing and furnishing this information.

Printed Name of Patient | Signature of Patient/Legal Representative | Date

□ Allen □ Flower Mound □ Irving □ Plano □ Weatherford

North Texas Diabetes & Endocrinology

Medical History

NAME		DATE			
DOB		AGE		SEX	

BRIEFLY DESCRIBE YOUR MAIN PROBLEMS:

PAST PHYSICIANS/ HOSPITAL HISTORY

Allergies ☐ Yes ☐ No Known Allergies (NKDA)

Allergy:	What reactions did you have:	Onset Date:
_____	_____	_____
_____	_____	_____
_____	_____	_____

CURRENT MEDICATION

Name	Dosage	Reason
1		
2		
3		
4		
5		
6		

PAST MEDICAL HISTORY

☐ Other _____	☐ Claustrophobic	☐ Heart Disease	☐ Obesity
☐ ADD or ADHD	☐ Congenital Heart Disease	☐ Heart Problems	☐ Organ Transplant
☐ Alcohol or Drug Abuse	☐ Congestive Heart Failure	☐ Heart Valve Disorder	☐ Osteoarthritis
☐ Allergies	☐ Constipation	☐ Heart Arrhythmia	☐ Osteopenia
☐ Anxiety Disorder	☐ Depression	☐ Heart Attack (MI)	☐ Osteoporosis
☐ Aortic Aneurysm	☐ Development/ Behavior Disorder	☐ Heart Murmur	☐ Otitis Media
☐ Arrhythmia	☐ Diabetes	☐ Hemophilia	☐ Pacemaker
☐ Arthritis	☐ Diverticulitis	☐ Hepatitis	☐ Previous Fracture
☐ Asthma	☐ Ear or Hearing Problems	☐ Hernia	☐ Psychiatric Illness
☐ Atrial Fibrillation	☐ Eczema, Hives, Skin Conditions	☐ Hiatal Hernia	☐ Pulmonary Embolism
☐ Back Pain	☐ Endometriosis	☐ Hypercholesterolemia	☐ Rheumatoid Arthritis
☐ Bedwetting	☐ Epilepsy	☐ Hyperlipidemia	☐ Seizures
☐ Birth Defects or Inherited Disease	☐ Eye Problems	☐ Hypertension	☐ Serious Illness or Injuries
☐ Bleeding Disorder	☐ Fibromyalgia	☐ Hyperthyroidism	☐ Shortness of Breath
☐ Blood Clots	☐ GERD	☐ Hypothyroidism	☐ Sleep Apnea / Sleep Disorder
☐ Breast Cancer	☐ Gastrointestinal Disease	☐ Joint Pain	☐ Stroke / CVA
☐ CAD	☐ Genitourinary Disease	☐ Kidney Disease	☐ Thyroid Problems
☐ COPD	☐ Gout	☐ Kidney Stones	☐ Tuberculosis
☐ Cancer	☐ HIV or AIDS	☐ Leg or Foot Ulcers	☐ Ulcers
☐ Chest Pain	☐ Head Trauma	☐ Liver Disease	☐ Urinary Tract Injection
☐ Chicken Pox	☐ Headaches or Migraines	☐ Muscle, Joint, or Bone Problems	☐ Urologist Disorder

North Texas Diabetes & Endocrinology

FAMILY HISTORY

	Diseases	Onset Age	Died of Age, if applicable
Father:			
Mother:			
Siblings:			
Spouse:			
Children:			
Other:			

SURGICAL HISTORY

Procedure	Surgery/ Date
1	
2	
3	

SOCIAL HISTORY

Smoking Status	Never	Current Everyday Smoker	Current Occasional Smoker	Former Smoker			**Packs Per Day?**
Chewing Tobacco	None	½ Day	2-4 a Day	5+ a Day			**Years of Use?**
Alcohol Intake	None	Occasional	Moderate	Heavy			**Years of Use?**
Caffeine Intake	None	Occasional	Moderate	Heavy			**Years of Use?**
Education	Less than 8th Grade	9th Grade	10th Grade	11th Grade	High School Graduate	2 Year College	4 Year College	Postgraduate
Sexual Orientation	Heterosexual	Homosexual	Bisexual				
Exercise Level	None	Occasional	Moderate	Heavy			
Diet	Regular	Vegetarian	Vegan	Gluten Free	Specific	Carbohydrate	Cardiac Diabetic
General Stress Level	Low	Medium	High				

Illicit Drug Use:		**Sunscreen Used Routinely**	Yes No
Smoke Alarm in Home	Yes No	**Advanced Directive**	Yes No
Sporting Activities:		**Sexually Active**	Yes No
Smoke Exposure	Yes No		

Family History of Heart Disease	Yes No	**Family History of Heart Disease before late 50's**	Yes No
Sexually Transmitted Disease	Yes No	**At Risk for TB**	Yes No
At Risk for Hep B	Yes No		

North Texas Diabetes & Endocrinology

FOR FEMALE PATIENTS ONLY			
Last Menstrual Cycle	Unknown	Approximate Date	Definite Date
Frequency of Cycle (days)		**Menses Monthly**	Yes No
Age of Menarche		**Prior Hysterectomy**	Yes No
Current Birth Control Method		**If Post-Menopausal, age at menopause**	
Date of Last Pap		**Number of Child Births**	
Sexually Active	Yes No	**Number of Pregnancies**	

PAST PREGNANCIES				
1				
Date: _____	# of Fetuses: _____	GA Weeks: _____	Labor Length (hrs) _____	Sex: Male Female
Delivery Type: _____	Anesthesia: Yes No	Delivery Place: _____		Preterm Labor Yes No
2				
Date: _____	# of Fetuses: _____	GA Weeks: _____	Labor Length (hrs) _____	Sex: Male Female
Delivery Type: _____	Anesthesia: Yes No	Delivery Place: _____		Preterm Labor Yes No
3				
Date: _____	# of Fetuses: _____	GA Weeks: _____	Labor Length (hrs) _____	Sex: Male Female
Delivery Type: _____	Anesthesia: Yes No	Delivery Place: _____		Preterm Labor Yes No
4				
Date: _____	# of Fetuses: _____	GA Weeks: _____	Labor Length (hrs) _____	Sex: Male Female
Delivery Type: _____	Anesthesia: Yes No	Delivery Place: _____		Preterm Labor Yes No
5				
Date: _____	# of Fetuses: _____	GA Weeks: _____	Labor Length (hrs) _____	Sex: Male Female
Delivery Type: _____	Anesthesia: Yes No	Delivery Place: _____		Preterm Labor Yes No

North Texas Diabetes & Endocrinology

SYSTEMS REVIEW

	Constitutional		Respiratory		Psychology
	Fatigue		Chest Pain		Anxiety
	Fever		Cough		Depression
	Weakness		Shortness of Breath		Irritability
	Weight Change		Wheezing		Mood Swings
	Dermatology / Integumentary		**Cardiology**		**Endocrinology**
	Bruising		Chest Pain		Cold Intolerance
	Eczema		Cough		Heat Intolerance
	Hair Loss		Edema		Sweating
	Hives		Extremity Complaints		Thirst
	Lesions / Ulcers		High Blood Pressure		**Neurology**
	Pigmentation Changes		Murmurs		Dizziness
	Rash		Palpitations		Fainting
	Skin Cancer		Syncope		Headache
	Skin Mass		**Urology**		Loss of Consciousness
	Sun Exposure		Blood in Urine		Memory Loss
	HEENT		Flank Pain		Tingling/ Numbness
	Change in Vision		Nocturia		**Hematology / Lymph**
	Changes in Sense of Smell		Pubic Pain		Anemia
	Difficulty Hearing		Urinary Incontinence		Bleeding Tendencies
	Difficulty Swallowing		Urinary Frequency		**Allergy**
	Double Vision		Urinary Pain		Ear Symptoms
	Dry Mouth		Urinary Urgency		Hives
	Ear Pain		**Gastroenterology**		Itchy Eyes
	Eye Pain		Blood in Stool		Congestion
	Hearing Loss		Constipation		Season Symptoms
	Mouth Disorder		Diarrhea		Sneezing
	Mouth Sores		Heartburn		
	Nosebleeds		Hemorrhoids		
	Pain in Throat/ Swallowing		Jaundice		
	Ringing in Ears		Nausea		
	Sore Throat		Reflux		
			Stool Changes		
			Vomiting		

North Texas Diabetes & Endocrinology

Dr. Muhammad Choudhry

CIRCLE OF CARE

Patient Name:_____ DOB: _____

List all physicians you see:

Name: Dr. Muhammad Choudhry	**Specialty:** Endocrinology
Address: 945 Hilltop Dr, St 101, Weatherford, TX 76086	**Phone/ Fax:** Ph. (817) 458 – 4985 / Fax: (469) 405 - 5441
Name:	**Specialty:**
Address:	**Phone/ Fax:**
Name:	**Specialty:**
Address:	**Phone/ Fax:**

Name:	**Specialty:**
Address:	**Phone/ Fax:**
Name:	**Specialty:**
Address:	**Phone/ Fax:**
Name:	**Specialty:**
Address:	**Phone/ Fax:**

Name:	**Specialty:**
Address:	**Phone/ Fax:**

North Texas Diabetes & Endocrinology

Diabetes Questionnaire - Initial visit

Patient name: _____ DOB: _____/_____/_____

Date: _____/_____/_____

Year diagnosed with diabetes: _____

1. How frequently do you check your glucose level? _____ per/ ☐ day ☐ week

2. Do you wear a Continous Glucose Monitoring (DGM) device? ☐ yes ☐ no

3. What are your glucose numbers?

	Range	Average
Breakfast		
Lunch		
Dinner		
Bedtime		
After meals		

4. Are you taking insulin? ☐ yes ☐ no If yes, when did you start taking insulin? _____

5. What is your insulin dosage?

	Breakfast	Lunch	Dinner	Bedtime
Long acting:				
Short Acting:				

Sliding Scale? ☐ yes ☐ no

Insulin Pump? ☐ yes ☐ no

6. How many low blood glucose reactions do you have in a ☐ week ☐ month _____

7. Other medications for diabetes and dosage:

	Dose:
Jardiance/Farxiga/Steglatro/Invokana	_____
Metformin (Glucophage and Glucophage XR)	_____
Pioglitaone (Actos)	_____
Glipizide (Glucotrol and Glucotrol XL) / Glimepiride	_____
Prandin/Starlix	_____
Trulicity/Ozempic/Victoza/Bydureon/Rybelsus	_____

8. Last hemoglobin A1C (Glycohemoglobin) result was _____ Date: _____/_____/_____

9. Last visit with the eye specialist was on? Date: _____/_____/_____

10. Other diabetes complications: ☐ yes ☐ no

Kidney problems / Neuropathy / Foot ulcer / Amputation / Heart attack / Impotence / Heart Failure

Any other:

_____

North Texas Diabetes and Endocrinology of Weatherford, A Premier Health Partner
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