List any fractures (broken bones), which bone fractured, when, and cause of fracture.

_____

_____

Physical activity/exercise. List type and how often._____

_____

Allergies. _____

_____

Medications._____

_____

_____

Also please circle any of the following which apply to you (past or present).

Anemia	Anorexia/Eating disorder	Black stools	Cancer (type)_____
Chicken Pox	Measles Mumps	Small Pox	Crohn's Disease
Cystic Fibrosis	Diabetes (how long)_____	Epilepsy	Gall Bladder Disease
Heart Disease		Hepatitis	High Blood Pressure
Hypogonadism(low male hormone)		Jaundice	Liver failure
Malabsorption /multiple stools (greater than 3 times per day)			Mastocytosis(skin reaction)
Multiple Myeloma			Palpitations(heart racing)
Pneumonia	Rheumatic Fever	Scarlet Fever	Seizure disorder

Steroid (prednisone/medrol) use (type and how long)_____

Thyroid Disease type_____		Goiter	Cushings Disease
Tuberculosis	Typhoid Fever	Whooping Cough	Ulcerative Colitis
Menopause age _____		No menstral periods	

N E O E

NorthEast Ohio Endocrinology
and Osteoporosis Institute

Welcome. To assist us with completing your evaluation, please answer the following questions. Thank you.

Name. _____ Date. _____

Age. _____

Sex. _____

Ethnic background. _____

Family History of Osteoporosis, Thyroid Disease, Diabetes, Cancer, Heart Disease, or other illness (Who and at what age).

_____

_____

Tobacco/cigarette use (type and how long). _____

Caffeine use (approximate amount per day). _____

Alcohol use. _____

Dairy/calcium intake (amount per day). _____

Past medical history. _____

_____

Past surgical history. _____

_____

Immobilization (ie. extended bed rest, lengthy casting, routine inactivity). List type and for how long.

_____

_____

Please continue on other side

IN CASE OF EMERGENCY **TELEPHONE**

(Please list someone not living at your residence – other than those listed on the reverse side. Neighbor, friend, relative, etc.)

NAME _____ **Day – ( )** _____

ADDRESS _____ **Night- ( )** _____

CITY _____ **STATE** _____ **ZIP** _____ **Relationship** _____

Please remember that insurance is considered a method of reimbursing the patient fees paid to the doctor and not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance.

IN ORDER TO CONTROL YOUR COST OF BILLINGS, WE REQUEST THAT OUR CHARGES FOR OFFICE VISITS BE PAID AT THE CONCLUSION OF EACH VISIT.

If this account is assigned to an attorney for collection and/or suit, the practice shall be entitled to reasonable attorney's fees and costs of collection.

I authorize the release of any information necessary to determine liability for payment and to obtain reimbursement on any claim.

I request that payment of the authorized benefits be made on my behalf. I assign the benefits payable to which I am entitles including Medicare, private insurance and other health plans to the practice named on the other side of this form.

The assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance.

THANK YOU FOR YOUR COOPERATION

Notice to our patients:

Please email or call our office during business hours to cancel your appointment.

We require a 48 hour notice.

You will be billed $50.00 if appointments are not canceled in the requested time.

Thank you,
Northeast Ohio Endocrinology

Signed _____

Date _____

NEOE

NEW PATIENT REGISTRATION

ACCOUNT #	DATE	PHYSICIANS NAME			
PATIENTS FIRST NAM	MIDDLE NAME	LAST		BIRTHDATE	AGE
ADDRESS	CITY	STATE	ZIP CODE		
SOCIAL SECURITY #	HOME PHONE #	WORK PHONE #	WORK OR BUSINESS PHONE #	MARITAL STATUS	SEX
EMPLOYERS NAME AND ADDRESS	RACE	☐ 01 AFRICAN AMERICAN ☐ NATIVE AMERICAN ☐ 02 ASIAN ☐ 11 OTHER ☐ CAUCASIAN ☐ HISPANIC			
EMAIL ADDRESS	PRIMARY LANGUAGE				
PHARMACY OF CHOICE	PHARMACY PHONE #				
HOW WERE YOU REFERED TO NEOE?					
HAVE YOU BEEN TREATED BY NEOE A PHYSICIAN PREVEIOUSLY? ☐ YES ☐ NO					

PERSON/GAURANTOR RESPONSIBLE FOR PAYMENT OF SERVICES (IF DIFFERENT FROM PATIENT)

FIRST NAME	MIDDLE NAME	LAST	RELATIONSHIP TO PATIIENT		
ADDRESS	CITY	STATE	ZIP CODE		
SOCIAL SECURITY #	HOME PHONE #	WORK PHONE #	WORK OR BUSINESS PHONE #	BIRTHDATE	SEX
EMPLOYERS NAME AND ADDRESS					

EMERGENCY CONTACT (NOT WITHIN THE HOUSEHOLD)

NAME	EMERGENCY PHONE NUMBER	RELATIONSHIP TO PATIENT

INSURANCE INFORMATION

PRIMARY INSURANCE		SECONDARY INSURANCE	
INSURANCE NAME	EFFECTIVE DATE	INSURANCE NAME	EFFECTIVE DATE
CLAIM ADDRESS		CLAIM ADDRESS	
.SUNSCRIBER ID NUMBER	GROUP NUMBER	SUBCRIBER NUMBER	GROUP NUMBER
SUBSCRIBER NAME AND ADDRESS		SUBSCRIBER NUMBER AND ADDRESS	
SUBSCRIBER BIRTHDATE		SUBSCRIBER BIRTHDATE	
SUBSCRIBER SSN#	RELATIONSHIP TO PATIENT	SUBSCIBER SSN#	RELATIONSHIP TO PATIENT
EMPLOYER NAME, ADDRESS AND OHONE NUMBER		EMPLOYER NAME, ADDRESS AND PHONE NUMBER	
FOR PRESCRIPIONS DO YOU USE YOUR ☐ PRIMARY INSURANCE ☐ SECONDARY INSURANCE ☐ OTHER			

The Patient or Guarantor is responsible for payment in full of all services rendered by the physicians or employees of NEOE. Payment in full is expected at the time of service unless arrangements are made in advance

AUTHORIZATION, ASSIGNMENT, AND RESPONIBILITY OF ACCOUNT.

I hereby authorize NEOE to release to the above insurance companies &/or carriers any medical or other information needed for claims reimbursement. I hereby assign, transfer and set over to NEOE all my rights, title, and interest to medical reimbursement benefits under my insurance policy with the above documented insurance companies. I hereby acknowledge and accept responsibility for payment in full of all services rendered to me by NEOE.

DATE

SIGNATURE OF PATIENT/GAURDIAN