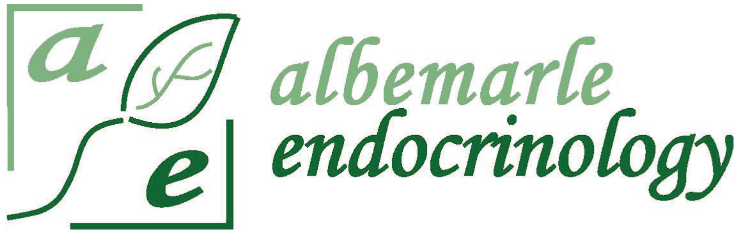

Albemarle Endocrinology PLC

600 Peter Jefferson Pkwy, Suite 200

Charlottesville VA 22911

Telephone 434-244-0934 Fax 434-244-0935

Dear Patient :

Please arrive 10 minutes early for your appointment and bring the **completed** enclosed forms.

We already have your records and Insurance referral, if needed. Also please remember to bring all your medications, your photo ID and your insurance card/s with you to this appointment/visit.

We look forward to seeing you in our office.

Sincerely,

Sandhya Chhabra, M.D. and staff

PATIENT REGISTRATION

Name: __________________________________ Sex:_____ Age: ____ Birthdate_____________

Address: ______________________________________City_________ State:_____ Zip:_______

Home Phone: __________________ Work Phone:_______________ Cell Phone_____________

Email Address____

What is your preferred means of communication (Phone, email, mail) ____________________

May we leave a voice mail message? ____________________________

Social Security:_______________________ Marital Status: S M W D Separated

Employer's Name____

Employer's Address ____

Spouse's Name ________________________________ Spouse's Birthdate: _________________

Spouse's Employer:____

Next of Kin (not living with you): ____

Home Phone: ____________________________ Work Phone: ____________________________

Name of Primary Care Physician: ____

Names of other physicians you want us to send records to:____

____

How did you hear about our practice? Primary Care Physician, web search, Yellow Pages, family, friend or other: _____________
____

Who else can contact us for records and information (please give names)__________________________

RELEASE & ASSIGNMENT

I hereby consent to any necessary medical diagnosis and treatment for myself, child, or above –named individual for whom I am legally responsible. The release of medical information to any insurance carrier and direct payment to the practice for any treatment or examination rendered is authorized. I hereby acknowledge and accept final responsibility for payment of charges for medical services rendered.

____ _______________________

Signature Date

OUR OFFICE POLICY

We are committed to providing you with the best possible care, and we are pleased to discuss our professional fees with you. Your clear understanding of our financial policy is important to our professional relationship. We will be happy to answer any questions you may have.

Albemarle Endocrinology PLC participates and accepts assignment of insurance benefits of most insurance organizations. Of course, you are still responsible for the timely payment of deductibles, co-insurance, and/or co-payments. Co-payments are due at the time of your visit.

If you have insurance with an organization that we do not participate with, provide us with adequate information and we will bill your insurance company for you. In these cases, payment of your bill remains your responsibility, including any balance after your insurance company settles your claim.

If you insurance company requires a referral from your primary care physician, and one was not obtained, you are responsible for any balances not paid by the insurance company. It is your responsibility to make sure your PCP does the necessary referrals to Dr. Chhabra/Albemarle Endocrinology.

I understand by signing below that I will be responsible for any balances not paid by my insurance.

CANCELLATION POLICY

We require a minimum of 24 hour notice of change or cancellation. With a 24 hour notice, you will not incur a cancellation fee ($50.00). This includes: Rescheduling appointment, Cancelling appointment and No showing up for your appointment. With notice, it allows us to schedule a patient that may wish to have an earlier appointment. We appreciate your consideration & courtesy.

NOTICE OF PRIVACY PRACTICES

Albemarle Endocrinology PLC has a Notice of Privacy Practices, which describes how we may use and disclose your protected health information and how you can access your protected health information and exercise other rights concerning our acknowledgement and consent. We are happy to provide a copy of our Privacy Practices for your review.

ACKNOWLEDGEMENT & CONSENT

I have been given a copy of the Notices of Privacy Practices (if requested), which describes how we may use or disclose your protected health information and how you can access your protected health information and exercise other rights concerning our acknowledgement and consent.

____ _________________________

(Print patient name Date of Birth

For treatment, payment and healthcare operations purposes consistent with its Notice of Privacy Practices, including discussions with family members (unless otherwise requested).

_______________________________________ _________________________________

Signature Date

New Patient History Form

Name: ____ Sex: ____ Age: _____ Birthdate: ___________

Please complete this form and bring it with you when you come to our office. Thank you

REASON FOR VISIT: ____

ALLERGIES: Allergy to any drug: ____

X-Ray Dye _________________ Food ___________________________________

MEDICATIONS: List current medications and dosage, including over the counter medications and supplements.

Medication Dose Frequency	Medication Dose Frequency

FAMILY HISTORY: Has any member of your immediate family had any of the following?

If YES, please note relationship

Thyroid Disease ____

Diabetes ____

High Blood Pressure ____

Heart Disease ____

Cholesterol ____

Stroke ____

Osteoporosis ____

Infertility ____

Obesity ____

Other pertinent history ____

____

PAST MEDICAL HISTORY: Please list all medical illnesses below and report year of onset

____

____

HOSPITALIZATIONS: Were you ever hospitalized for operations, illness, or injury?

Reason/Year	Reason/Year

For Women Only:

How old were you when you had your first menstrual cycle? ________________________________

Do you have regular/monthly menses? ____

Have you gone through menopause? ____________ No ___________ Yes ________ What age?

How many times have you been pregnant? ___________________________

How many children have you had? ________________________

How many miscarriages have you had? ____________________

How many abortions have you had? ______________________

Do you currently use a method to prevent pregnancy? ___________ Yes __________ No

If so, what method do you use? ____

SOCIAL HISTORY:

Habits: Do you smoke? Yes No Packs per day? _________________

Past Smoking History Yes No Packs per day? _____When stopped? __________

Do you drink alcoholic beverages? Yes No How much? ______________________________

(If you use illicit drugs, please speak to us in confidence.)

Do you exercise Yes No How often? ______________________________

Occupation: ____

Hobbies/Social activities: ____

Whom do you live with, if anyone? ____

Are you:
- Single
- Married
- Divorced
- Separated
- Engaged
- In a relationship
- Widow/Widower

Are you retired? ______________________ Are you now disabled? ___________________________