Patient Information:

Date: _____

Last Name: _____ First: _____ MI: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: ( ) _____ Work Phone: ( ) _____

Date of Birth: _____ Age: _____ Texas D.L. #: _____

Sex: M F Marital Status: _____ If Married, Spouse Name: _____

Social Security #: _____ Referred By: _____

Employer: _____ Position: _____

Address: _____ City: _____ State: _____ Zip: _____

Referred by: _____

Nearest Relatives Not Living with you: Relationship: _____

Name: _____ Telephone Number: ( ) _____

Primary Insurance: _____

Mailing Address for Ins. Claims: _____ Ins. ID #: _____

City: _____ State: _____ Zip: _____ Phone: ( ) _____

Group Name\#: _____ SSN: _____

Insured Party Name: _____ DOB: _____ Rel. to Patient: _____

Address: _____ City: _____ State: _____ Zip: _____

Employer: _____ Phone: ( ) _____

Secondary Insurance: _____

Mailing Address for Ins. Claims: _____ Ins. ID #: _____

City: _____ State: _____ Zip: _____ Phone: ( ) _____

Group Name\#: _____ SSN: _____

Insured Party Name: _____ Relationship to Patient: _____

Address: _____ City: _____ State: _____ Zip: _____

Employer: _____ Phone: ( ) _____

We do have a pay as you go policy.

I realize that my insurance company, or Medicare, or other agencies may pay all, a portion of, or none of the professional fees incurred. I recognize and accept personal responsibility for any balance remaining after payment of such benefits. I authorize Dr. Gardner to release any medical information necessary to process claims. I also permit payment to be made directly to Dr. Gardner. I understand and accept the above stated policies as indicated by signing my name below. A photostatic copy of my signature will serve as an original.

Signed: _____ Date: _____

REORDER # 05-05510-30

Memorial City Endocrine Consultants

1140 BUSINESS CENTER DR, SUITE 550, HOUSTON, TEXAS 77043
PHONE: 713-984-8200 FAX: 713-984-1113

Donald F. Gardner, MD, FACP **Kimberlee K. Perras, NP** **Ashley M. Watson, NP,ANP-BC**

HEALTH QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

Name: _____ ☐ M ☐ F **Today's Date:** _____

Address: _____
Street City State Zip

Age: _____ **Date of Birth:** _____ **Marital status:** ☐ Single ☐ Married ☐ Partnered ☐ Separated ☐ Divorced ☐ Widowed

Occupation: _____ **Employer:** _____

Referred By: _____

Briefly describe in your own words the problems which caused you to consult a physician today:

FAMILY HISTORY

RELATIVE	AGE	DECEASED Yes	DECEASED No	ILLNESSES	PHYSICIAN'S COMMENTS
Father	_____	☐	☐		
Mother	_____	☐	☐		
Brother / Sister	☐ M ☐ F ___	☐	☐		
	☐ M ☐ F ___	☐	☐		
	☐ M ☐ F ___	☐	☐		
	☐ M ☐ F ___	☐	☐		
	☐ M ☐ F ___	☐	☐		
	☐ M ☐ F ___	☐	☐		
Children	☐ M ☐ F ___	☐	☐		
	☐ M ☐ F ___	☐	☐		
	☐ M ☐ F ___	☐	☐		
	☐ M ☐ F ___	☐	☐		
	☐ M ☐ F ___	☐	☐		
	☐ M ☐ F ___	☐	☐		

Have any of your relatives (parents, brothers, sisters or children) had any of the following?

	Yes	No
Heart attack	☐	☐
Stroke	☐	☐
High blood pressure	☐	☐
Diabetes	☐	☐
High cholesterol	☐	☐
Thyroid trouble	☐	☐
Tuberculosis	☐	☐
Cancer	☐	☐
High Calcium	☐	☐

MEDICATIONS

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers

Drug Name	Dose	Times per day

Allergies to medications

Drug Name	Side effects or Reactions

Other Allergies

Have you ever had a very severe or life threatening reaction to any substance? ☐ ☐

If yes, please explain:

HABITS

Alcohol	Do you drink alcohol?	☐	Yes	☐	No
	How many drinks per week?				
Tobacco	Do you use tobacco?	☐	Yes	☐	No
	☐ Cigarettes ☐ Cigars ☐ Chew ☐ Pipe				
	☐ # of years ☐ Or year quit				
Drugs	Do you currently use recreational drugs?	☐	Yes	☐	No

HOSPITALIZATIONS

Date **Reason**

Other hospitalizations

Date **Illness / Operation**

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING:

General and Endocrine

	Yes	No
Fatigue	☐	☐
Fever	☐	☐
Weight gain or loss	☐	☐
(more than 5 lbs in last year)	☐	☐
Diabetes	☐	☐
Elevated cholesterol	☐	☐
Excessive thirst or urination	☐	☐
Problems with warm or cold	☐	☐
temperatures	☐	☐
Excessive snoring or sleepiness	☐	☐
Bleeding disorder or coagulation problems	☐	☐
Weakness	☐	☐

Head and Neck

	Yes	No
Fainting or blackouts	☐	☐
Difficulty with vision	☐	☐
Glaucoma	☐	☐
Frequent or severe headaches	☐	☐
Stroke or paralysis	☐	☐
Seizures or epilepsy	☐	☐
Difficulty swallowing	☐	☐
Persistent hoarseness	☐	☐
Thyroid trouble or enlarged thyroid (goiter)	☐	☐
Head or neck pain	☐	☐

Chest and Circulatory

	Yes	No
Persistent cough	☐	☐
Shortness of breath	☐	☐
Wheezing or asthma	☐	☐
Coughing up blood	☐	☐
High blood pressure	☐	☐
Chest pain	☐	☐
Heart attack	☐	☐
Heart murmur or other heart trouble	☐	☐
Heart palpitations or racing	☐	☐
Swelling or collection of fluid in the legs and ankles	☐	☐
Tuberculosis or positive TB Skin Test	☐	☐
Abnormal chest x-ray	☐	☐
Phlebitis or blood clots	☐	☐
Pain in the legs when walking	☐	☐

Abdomen

	Yes	No
Indigestion or heartburn	☐	☐
Recent abdominal pain	☐	☐
Stomach or duodenal ulcer	☐	☐
Problems with constipation	☐	☐
Recurrent or severe diarrhea	☐	☐
Recent nausea or vomiting	☐	☐
Gallstones	☐	☐
Yellow jaundice or hepatitis	☐	☐
Blood in stools	☐	☐

Kidney and Bladder

	Yes	No
Burning on urination	☐	☐
Waking at night to urinate	☐	☐
Kidney stones	☐	☐
Blood in the urine	☐	☐
Difficulty starting your urine or poor stream	☐	☐
Kidney disease or nephritis	☐	☐
History of bladder or kidney infection	☐	☐

Musculoskeletal

	Yes	No
Fractures or broken bones If yes, please list:	☐	☐
Osteoporosis	☐	☐
Recurrent or severe low back pain or strain	☐	☐
History of arthritis (pain, swelling, or stiffness of joints)	☐	☐
Frequent muscle cramps	☐	☐
Bone or muscle pain	☐	☐

Women Only

	Yes	No
Discharge from breasts	☐	☐
Other breast problems	☐	☐
Irregular menstrual periods	☐	☐
Abnormal periods in any way (heavy flow, severe cramps, spotting)	☐	☐
Problems with sexual function	☐	☐
Excessive hair growth	☐	☐

Men Only

	Yes	No
Problems with sexual function or intercourse	☐	☐
Prostate problems	☐	☐
Difficulty having or maintaining erections	☐	☐
Enlargement of the breasts	☐	☐

Emotional

	Yes	No
Problems with nervousness, anxiety or tension	☐	☐
Feelings of depression	☐	☐
Difficulty sleeping	☐	☐
Received care from a psychiatrist	☐	☐
Seriously considered suicide	☐	☐

FOR DIABETIC PATIENTS – PLEASE CONTINUE TO NEXT PAGE

FOR DIABETIC PATIENTS ONLY

Age at diagnosis of diabetes? _____

Weight at the time of diagnosis? _____

Have you ever been treated for ketoacidosis? Yes ☐ No ☐

If yes, how many times? _____

Date of last episode? _____

Do you test your own blood sugar? Yes ☐ No ☐

How often do you test your blood sugar?

_____

_____

What do your blood sugar tests usually show?

Before breakfast _____

Before lunch _____

Before supper _____

Before bedtime _____

	Yes	**No**
Do you have or have you had:		
Protein in the urine?	☐	☐
Kidney disease from diabetes?	☐	☐
Eye disease from diabetes (retinopathy)?	☐	☐
Laser treatments for your eyes?	☐	☐
Ulcers of the feet or skin?	☐	☐
Are you taking an oral hypoglycemic tablet (a pill for diabetes)?	☐	☐
Have you ever had low blood sugar reactions from the diabetes tablet?	☐	☐
Numbness, burning or tingling of the hands or feet?	☐	☐
Frequent urination?	☐	☐
Excessive thirst?	☐	☐
Yeast (fungus) infections of the skin?	☐	☐
Weight change in the last year?	☐	☐
If yes, how much have you gained or lost?	Gained _____	
	Lost _____	

Describe your diet:

Number of snacks _____

Do you use carbohydrate counting? Yes ☐ No ☐

What was the date of your last appointment with your ophthalmologist (physician who specializes in treatment of eye diseases)? _____

Date Physician Name

FOR DIABETIC PATIENTS WHO USE INSULIN

Do you use insulin injections? Yes ☐ No ☐

Type of insulin	Units	Times
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you have insulin reactions? Yes ☐ No ☐

How often do your reactions occur? _____ per day
_____ per week
_____ Per month

At what time or times per day do your reactions occur?
If there is no pattern, write "no pattern":

_____
_____
_____

Have you ever had loss of consciousness with an insulin reaction? Yes ☐ No ☐

Have you ever had an epileptic seizure (a convulsion) due to a severe insulin reaction? Yes ☐ No ☐

Are you currently using an insulin pump? Yes ☐ No ☐

NOTICE OF PRIVACY PRACTICES
Memorial City Endocrine Consultants

Effective Date: _____

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you have any questions about this Notice, please contact:
Ms. Shernika Paige at 713-984-8200

WHO WILL FOLLOW THIS NOTICE?

Providers
All employees

We understand that medical information about you and your health is personal and are committed to protecting this information. When you receive care at Memorial City Endocrine Consultants, a record of the care and services you receive is made. Typically, this record contains your treatment plan, history and physical, test results, and billing record. This record serves as a:

- Basis for planning your treatment and services;
- Means of communication among the physicians and other health care providers involved in your care;
- Means by which you or a third-party payor can verify that services billed were actually provided;
- Source of information for public health officials; and
- Tool for assessing and continually working to improve the care rendered.

This notice tells you the ways we may use and disclose your Protected Health Information (referred to herein as "medical information"). It also describes your rights and our obligations regarding the use and disclosure of medical information.

OUR RESPONSIBILITIES:

Memorial City Endocrine Consultants shall:

- Make every effort to maintain the privacy of your medical information;
- Provide you with notice of our legal duties and privacy practices with respect to information we collect and maintain about you;
- Abide by the terms of this notice;
- Notify you if we are unable to agree to a requested restriction; and
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.
- Memorial City Endocrine Consultants will notify you, and the Department of Health & Human Services, of any unauthorized acquisition, access, use or disclosure of your unsecured medical information that presents a significant risk of financial, reputational or other harm to you, to the extent required by law. Unsecured medical information means medical information not secured by technology that renders the information unusable, unreadable, or indecipherable as required by law.

THE METHODS WHICH WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU

The following categories describe different ways we may use and disclose your medical information. The examples provided serve only as guidance and do not include every possible use or disclosure.

- **For Treatment.** We will use and disclose your medical information to provide, coordinate, or manage your health care and any related services. For example, we may share your information with your primary care physician or other specialists to whom you are referred for follow-up care.
- **For Payment.** We will use and disclose medical information about you so that the treatment and services you receive may be billed and payment may be collected from you, an insurance company, or a third party. For example, we may need to disclose your medical information to a health plan in order for the health plan to pay for the services rendered to you.
- **For Health Care Operations.** We may use and disclose information about you for office operations. These uses and disclosures are necessary to run Memorial City Endocrine Consultants in an efficient manner and provide that all patients receive quality care. For example, your medical records and health information may be used in the evaluation of services, and the appropriateness and quality of health care treatment. In addition, medical records are audited for timely documentation and correct billing.
- **Appointment Reminders.** We may use and disclose medical information in order to remind you of an appointment. For example, Memorial City Endocrine Consultants may provide a written or telephone reminder that your next appointment with Memorial City Endocrine Consultants is coming up.
- **Research.** Under certain circumstances, we may use and disclose medical information about you for research purposes. For example, a research project may involve comparing the surgical outcome of all patients for whom one type of procedure is used to those for whom another procedure is used for the same condition. All research projects, however, are subject to a special approval process. Prior to using or disclosing any medical information, the project must be approved through this research

approval process. We will ask for your specific authorization if the research will have access to your name, address, or other information that reveals who you are, or will be involved in your care.

- **As Required by Law.** We may use and disclose medical information about you when required to do so by federal or Texas laws or regulations.
- **To Avert a Serious Threat to Health or Safety.** We may use and disclose medical information about you to medical or law enforcement personnel when necessary to prevent a serious threat to your health and safety or the health and safety of another person.
- **Sale of Practice.** We may use and disclose medical information about you to another health care facility or group of physicians in the sale, transfer, merger, or consolidation of our practice.

SPECIAL SITUATIONS.

- **Organ and Tissue Donation.** If you have formally indicated your desire to be an organ donor, we may release medical information to organizations that handle procurement of organ, eye, or tissue transplantation.
- **Military and Veterans.** If you are a member of the armed forces, we may release medical information about you as required by military command authorities.
- **Workers' Compensation.** We may release medical information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.
- **Qualified Personnel.** We may disclose medical information for management audit, financial audit, or program evaluation, but the personnel may not directly or indirectly indentify you in any report of the audit or evaluation, or otherwise disclose your identity in any manner.
- **Public Health Risks.** We may disclose medical information about you for public health activities. These activities generally include the following activities:
  - To prevent or control disease, injury, or disability;
  - To report reactions to medications or problems with products;
  - To notify people of recalls of products they may be using;
  - To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and
  - To notify the appropriate government authority if we believe you have been the victim of abuse, neglect, or domestic violence.

  All such disclosures will be made in accordance with the requirements of Texas and federal laws and regulations.
- **Health Oversight Activities.** We may disclose medical information to a health oversight agency for activities by law. Health oversight agencies include public and private agencies authorized by law to oversee the health care system. These oversight activities are necessary for the government to monitor the health care system, government programs, eligibility or compliance, and to enforce health-related civil rights and criminal laws.
- **Lawsuits and Disputes.** If you are involved in certain lawsuits or administrative disputes, we may disclose medical information about you in response to a court or administrative order.
- **Law Enforcement.** We may release medical information if asked to do so by a law enforcement official:
  - In response to a court order or subpoena; or
  - Determines probability of imminent physical injury to you or another person, or immediate mental or emotional injury to you.
- **Coroners, Medical Examiners and Funeral Directors.** We may release medical information to a coroner or medical examiner when authorized by law (*e.g.,* to identify a deceased person or determine the cause of death). We may also release medical information about patients to funeral directors.
- **Inmates.** If you are an inmate of a correctional facility, we may release medical information about you to the correctional facility for the facility to provide you treatment.
- **Other Uses or Disclosures.** Any other use or disclosure of PHI will be made only upon your individual written authorization. You may revoke an authorization at any time provided that it is in writing and we have not already relied on the authorization.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU.

You have the following rights regarding medical information collected and maintained about you:

- **Right to Inspect and Copy.** You have the right to inspect and copy medical information that may used to make decisions about your care. Usually, this includes medical and billing records.

  To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to the Medical Records Custodian for Memorial City Endocrine Consultants. If you request a copy of the information, Memorial City Endocrine Consultants may charge a fee established by the Texas Medical Board for the costs of copying, mailing, or summarizing your records.

  Memorial City Endocrine Consultants may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by Memorial City Endocrine Consultants will review your request and denial. The person conducting the

review will not be the person who denied your request. Memorial City Endocrine Consultants will comply with the outcome of the review.

- **Right to Amend.** If you feel the medical information maintained about you is incorrect or incomplete, you may ask Memorial City Endocrine Consultants to amend the information. You have the right to request an amendment for as long as the information is kept by Memorial City Endocrine Consultants.
  To request an amendment, your request must be made in writing and submitted to Memorial City Endocrine Consultants. In addition, you must provide a reason to that supports your request.
  Memorial City Endocrine Consultants may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, Memorial City Endocrine Consultants may deny your request if you ask us to amend information that:
  - Was not created by Memorial City Endocrine Consultants, unless the person or entity that created the information is no longer available to make the amendment;
  - Is not part of the medical information kept by Memorial City Endocrine Consultants;
  - Is not part of the information which you would be permitted to inspect and copy; or
  - Is accurate and complete.
- **Right to an Accounting of Disclosures.** You have the right to request an "accounting of disclosures." This is a list of the disclosures made of your medical information for purposes other than treatment, payment, or health care operations.
  To request this list you must submit your request in writing to Anita B. Higgins, the Medical Records Custodian. Your request must state a time period, which may not be longer than six (6) years. Your request should indicate in what form you want the list (for example, on paper or electronically). The first list you request within a 12-month period will be free. For additional lists within the 12-month period, you may be charged for the cost of providing the list. Memorial City Endocrine Consultants will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the medical information Memorial City Endocrine Consultants uses or discloses about you for treatment, payment, or health care operations. You also have the right to request a limit on the medical information Memorial City Endocrine Consultants discloses about you to someone who is involved in your care or the payment for your care.
  Memorial City Endocrine Consultants is not required to agree to your request, unless the request pertains solely to a healthcare item or service for which Memorial City Endocrine Consultants has been paid out of pocket in full. Should Memorial City Endocrine Consultants agree to your request, Memorial City Endocrine Consultants will comply with your request unless the information is needed to provide you emergency treatment.
  To request restrictions you must make your request in writing to Memorial City Endocrine Consultants. In your request, you may indicate: (1) what information you want to limit; (2) whether you want to limit Memorial City Endocrine Consultants use and/or disclosure; and (3) to whom you want the limits to apply.
- **Right to Request Confidential Communications.** You have the right to request that Memorial City Endocrine Consultants communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that Memorial City Endocrine Consultants contact you only at work or by mail.
  To request that Memorial City Endocrine Consultants communicate in a certain manner, you must make your request in writing to the Privacy Officer. You do not have to state a reason for your request. Memorial City Endocrine Consultants will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

CHANGES TO THIS NOTICE.

We reserve the right to change our practices and to make the new provisions effective for all PHI we maintain. Should our information practices change, we will post the amended Notice of Privacy Practices in our office and on our website. You may request that a copy be provided to you by contacting the Medical Records Custodian.

COMPLAINTS.

If you believe your privacy rights have been violated, you may file a complaint with Memorial City Endocrine Consultants or with the Office for Civil Rights, U.S. Department of Health and Human Services. To file a complaint with Memorial City Endocrine Consultants, contact the Office Manager at (713) 984-8200. Your complaint must be filed within 180 days of when you knew or should have known that the act occurred. The address for the Office of Civil Rights is:

Secretary of Health & Human Services
Region VI, Office for Civil Rights
U.S. Department of Health and Human Services
1301 Young Street, Suite 1169
Dallas, TX 75202

All complaints should be submitted in writing.

You will NOT be penalized for filing a complaint.

MEMORIAL CITY ENDOCRINE CONSULTANTS

Name:_____DATE:_____

DO WE HAVE PERMISSION TO?

Leave a message on your answering machine at home?	**Yes or No**
Leave test results or appointment confirmations on your answering machine at home?	**Yes or No**
Leave a message at your place of employment?	**Yes or No**
Leave a message on your cell phone voice mail?	**Yes or No**
Leave test results or appointment confirmations on your cell phone voice mail?	**Yes or No**
Send appointment reminder cards/missed appointment cards to you by mail?	**Yes or No**
Fax copies of your results to another physician if necessary?	**Yes or No**
If offered in the future would you like appointment reminders through email?	**Yes or No**

E-MAIL ADDRESS_____

Initial here_____

I have reviewed this office's Notice of Privacy Practice, which explains how my medical information will be use and disclosed. I understand that I am entitled to receive a copy of this document. **Initial here_____**

Please list any persons in which we have you permission to discuss your medical condition or test results:

_____ _____

_____ _____

Insured Patients
I authorized the release of any medical or other information necessary to process my insurance claims. I certify that the information I furnish is true and correct. **_____ Initial here**

I authorize payment of medical benefits to MEMORIAL CITY ENDOCRINE CONSULTANTS. I understand that I maybe responsible for any amount not paid by my insurance company if they are deemed non-covered items. **_____ Initial here**

Self Paid (non insured) Patients
I certify that I do not have insurance benefits and that I will not be filing to an insurance company for reimbursement of these charges. **_____ Initial here**

Signature of Patient or Personal Representative

Name of Personal Representative (If applicable)

Relationship to patient

Date

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice *of* Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the e right to change its Notice *of* Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice *of* Private practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name:_____

Relationship to Patient: _____

Signature:_____

Date:_____

_____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgment on this Notice of Privacy Practices Acknowledgment, but was unable to do so as documented below:

Date:_____ Initials:_____ Reason:_____

Pharmacy Information

We now have the ability to send prescriptions to your pharmacy electronically. Please fill out the following information so that we may add it to your data base.

Patient name: _____

Local pharmacy: _____

Local pharmacy address: _____

_____

Local pharmacy telephone no.:_____

Mail in prescription service (if used):_____

Mail in prescription service address: _____

_____

Mail in prescription service telephone no.:_____